STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AMENDMENT # 4
RFP # 318.65-219

June 9, 2006

The subject RFP is hereby amended as follows.

A. The following RFP Schedule of Events updates or confirms scheduled RFP dates.

	EVENT	TIME	DATE	UPDATED/ CONFIRMED
1.	State Issues RFP		April 7, 2006	CONFIRMED
2.	Disability Accommodation Request Deadline		April 17, 2006	CONFIRMED
3.	Pre-proposal Conference	10:00 a.m.	April 19, 2006	CONFIRMED
4.	Notice of Intent to Propose Deadline		April 21, 2006	CONFIRMED
5.	Written Comments Deadline		May 19, 2006	CONFIRMED
6.	State Responds to Written Comments		June 9, 2006	CONFIRMED
7.	Proposal Deadline	2:00 p.m.	June 30, 2006	CONFIRMED
8.	State Completes Technical Proposal Evaluations		July 24, 2006	CONFIRMED
9.	State Opens Cost Proposals & Calculates Scores	9:00 a.m.	July 25, 2006	CONFIRMED
10.	State Issues Evaluation Notice & Opens RFP Files for Public Inspection	9:00 a.m.	July 26, 2006	CONFIRMED
11.	Contract Signing		August 7, 2006	CONFIRMED
12.	Contract Signature Deadline		August 14, 2006	CONFIRMED
13.	Contract Start Date (Readiness Review/Transition Begins; Actual Delivery of Services begins on April 1, 2007)		August 15, 2006	CONFIRMED
14.	Delivery of Services		April 1, 2007	CONFIRMED

B. The following State responses to the questions detailed shall amend or clarify this RFP accordingly.

#	Proposer Name	Document Reference	Section Number	Page #	Question	Response
1	Windsor Health Plan	RFP	1.1	1	Why is the State limiting the number of carriers under this contract to two?	The State is limiting the number of carriers in the Middle Grand Region to two in order to provide choice to enrollees while minimizing the administrative complexity for the State.
2	CHCcares, Inc.	RFP	1.1	2	Will the Bureau consider awarding contracts to more than two MCOs to ensure that there is redundancy in the availability of managed care options for beneficiaries?	No.
3	Windsor Health Plan	RFP	1.1	5	Please provide more detail on the modified reform plan referenced on page 5 of the RFP? Are any additional reforms planned for SFYs 2006 and 2007?	The pro forma contract reflects the modified reform plan. At present, there are no additional reforms planned.
4	Windsor Health Plan	RFP	1.1	5	On page 5 it is stated, "Eligibility and membership in the program has stabilized". In examining the changes in enrollment mix between SFY 2004 and SFY 2005, significant changes occurred, What is the basis for the statement that eligibility and membership has stabilized? What is the current distribution for SFY?	As discussed in RFP Attachment 6.8, page 6, 191,000 members were disenrolled from the program as a result of new reforms to the TennCare program. The majority of these members were disenrolled during 2005. Subsequently, enrollment is considered to have stabilized. Refer to RFP Attachment 6.8 for membership data.
5	CHCcares, Inc.	RFP	1.5.7	8	Will the Bureau provide responses to questions raised in the RFI responses and during the 2005 RFI Bidder's conference?	Except for the update provided after the RFI conference (http://www.tn.gov/tenncare/healthplans/RFI/RFI_updates.htm), the State did not prepare formal response to questions raised in the RFI process. Therefore, the State cannot provide a copy of those responses. However, the comments and questions received during the RFI process were considered in developing this RFP.
6	Volunteer State Health Plan	RFP	1.5.8 and 1.5.10	8	Paragraph 1.5.8 states that "Only the State's official, written responses and communications shall be considered binding in regard to this RFP." However, paragraph 1.5.10 states that "Any factual information provided by the State, in this RFP or an official response or communication, shall be deemed for information purposes only....." Please clarify the difference.	Paragraph 1.5.10 refers to programmatic data or information that is provided to proposers.
7	Centene Corporation	RFP	1.5.10	8	How is the MCO expected to "independently verify the information" and data in the RFP and databook? What is the process to "obtain the State's written consent to rely" on information and data in the RFP and databook?	The State hereby provides written consent that the proposers may rely on the information and data in the RFP and its attachments, including the data book and any amendments to the RFP, in developing their proposals.
8	AMERIGROUP Corporation	RFP	1.8	9	Will the State publish a list of the Bidder Conference Attendees?	Refer to Section PP of this amendment.
9	CHCcares, Inc.	RFP	1.8	9	Will another Bidders' Conference meeting be scheduled to review any RFP changes and or questions as a result of the extension of the proposal submission deadline and document amendments?	No.
10	AMERIGROUP Corporation	RFP	2	11	Please consider moving the proposal final deadline to at least 30 days after the issue date of the last set of responses to bidder questions. This will allow bidders ample time to appropriately address all of the State's answers and clarifications.	The State respects the proposers need for sufficient time to prepare adequate responses in light of the State's answers and clarifications. As such, we have extended the period between the proposal final deadline and the issue date for responses from ten (10) calendar days to twenty-one (21) calendar days. It will not be further adjusted.
11	AMERIGROUP Corporation	RFP	2	11	Instead of releasing answers to bidder questions until June 9, will the State consider releasing written responses weekly or daily as the questions are resolved?	No. The State requires use of the allotted time to draft, review and ensure the accuracy of all responses.
12	CHCcares, Inc.	RFP	3.1.2.2	12	If attachments are in different Microsoft formats, such as Excel and Project, is it acceptable to have more than one attachment file?	Yes.

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13	John Deere	RFP	3.2	14	Requirement 3.2.2 states that offerors should duplicate the Technical Proposal & Evaluation Guide as the table of contents; however, requirement 3.2.4 also states that the requirement number and corresponding requirement text from the Technical Proposal & Evaluation Guide be provided in our response layout. Repeating the text would be a lot of duplication of content and increase the size of our total response. Can we instead use the major section headings and requirement #s for the table of contents instead? Is the RFP requirement language considered in the stated page counts?	No, you cannot just use the major section headings and requirement #s. You must also repeat the text. The RFP requirements language is considered in the stated page counts.
14	CHCcares, Inc.	RFP	3.2.3	14	What is considered reference material? May attachments and scanned images be exempt from the text no smaller than 11-point font, etc. requirements?	Reference material is all required attachments. Attachments and scanned images are exempt from the font size requirements.
15	Volunteer State Health Plan	RFP	3.3.2.2	15	Is the Bureau requiring an actuarial certification beyond the actuary's signature? To what is the actuary certifying? Can the actuary supply a memo detailing data limitations and qualifications?	As specified in RFP Section 3.3.2.2, the actuary's signature will indicate certification. The actuary is certifying that the rates developed are reasonable and appropriate and conform with actuarial standards of practice.
16	Windsor Health Plan	RFP	3.3.4.2	17	What portion of the TennCare population in the Middle Grand Region during SFY 2005 was being managed at the "loosely managed" utilization levels?	The total population in Middle Tennessee was deemed to be operating at a loosely managed care level in aggregate. The data was compiled in aggregate, allowing no differentiation between the existing MCOs. One may be at a higher/lower level than another.
17	Windsor Health Plan	RFP	3.3.4.2	17	Is the State assuming that MCOs can achieve the reductions in utilization levels assumed in the minimum capitation payment rates? Is this feasible in the context of Grier v. Goetz? And is the State going to further pursue getting this decision reversed or modified?	The State believes an MCO can operate within the rate ranges developed. It is up to the proposer to determine what they believe the managed care opportunity is.
18	Windsor Health Plan	RFP	3.3.4.2	17	How were the facility and professional providers being reimbursed during SFY 2005 (Methodology and Levels)?	Refer to State's Response #339.
19	Windsor Health Plan	RFP	3.3.7.1	18	Would the State be willing to eliminate the 3% change in the health status threshold? Would the State be willing to adjust the MCO's capitation payment rates every 6-months based on the change relative to the initial regional average? Given only 2% margin in the proposed capitation payment rates, the 3% health status change threshold appears to be very high.	The State will maintain the three percent (3%) threshold (positive or negative) to account for standard statistical variations inherent in any risk classification calculation. As specified in Sections 3.4.3.3 and 3.4.3.4 of the pro forma contract, MCO capitation payment rates will be adjusted annually and may be adjusted prior to the next scheduled annual recalibration if risk assessment score changes by three percent (3%) or more before then.
20	Windsor Health Plan	RFP	3.3.7.1	18	How would a change in the underlying health status of the population between SFY 2005 and CY 2007 be handled? Will the capitation payment rates by adjusted for any change?	Adjustments to the base data used to develop the rate ranges have been made for the following factors: individuals expected to be disenrolled prior to the start date of operations; populations excluded from MCO enrollment; incurred but not reported claims; and benefit changes. Further, the data was adjusted for medical cost/trend, administrative costs, third party liability and participant cost sharing, and managed care utilization savings to develop the rate ranges. Please refer to Attachment 6.8 for details. As specified in Section 3.4.3.1, health plan risk assessment scores will be initially recalibrated after current TennCare enrollees are assigned to the MCOs for retroactive application to payment rates effective on the start date of operations.
21	Centene Corporation	RFP	3.3.7.1	18	How will new entrants be handled with regards to the MCOs composite score? What ACG score will be assigned to them?	New entrants require 12 months of incurred claims data before they are factored into the analysis. All available claims data will be factored into the analysis.
22	Centene Corporation	RFP	3.3.7.1	18	Will TennCare Select be part of the Risk Adjusted plans?	No.

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23	Centene Corporation	RFP	3.3.7.1	18	Please provide a distribution of the ACGs for the current population by COA.	Refer to Section NN of this amendment.
24	Centene Corporation	RFP	3.3.7.1	18	Why are the MCO's health status risk adjustments only adjusted if they deviate from the regional profile by more than 3%? An MCO could lose 3% just because they are caring for a sicker population.	The three percent (3%) threshold (positive or negative) was put in place to account for standard statistical variations inherent in any risk classification calculation.
25	Volunteer State Health Plan	RFP	4.3.9.3	22	Please elaborate on circumstances under which it is possible for a person to be a former state employee within the past six months yet not trigger this clause.	The prohibition shall be applicable in instances where an employee or official of the State of Tennessee in a position that would allow the direct or indirect use or disclosure of information, which was obtained through or in connection with his or her employment and not made available to the general public, for the purpose of furthering the private interest or personal profit of any person. It would not apply in instances where the foregoing is not the case.
26	Volunteer State Health Plan	RFP	4.19	27	The contract amendments section discusses additional work that may be requested by the Bureau, and describes a process by which the MCO will be reimbursed. Will the Bureau incorporate this language into the Pro Forma Contract?	No.
27	AMERIGROUP Corporation	RFP	5.2.1.2	28	Will the proposal evaluation teams be formed into separate teams for purposes of review based on subject matter experts who will review the same section across all bidders or are the separate teams formed for a dedicated review of an individual bidder's entire proposal?	The evaluators will review and evaluate proposals across all bidders. Certain sections of each proposal (e.g., sections related to information systems) will be scored only by designated subject matter experts.
28	Volunteer State Health Plan	RFP	5.2.2	29	It is stated that in order for a Cost Proposal to be opened, the Technical Proposal must receive 490 points. Is the Qualifications and Experience considered part of the Technical Proposal (i.e. 490/700) or must the proposer score 490/500 in order to have their Cost Proposal opened?	The Qualifications and Experience questions are part of the Technical Proposal. A proposer must score 490 out of 700 in order to have their Cost Proposal opened.
29	CHCcares, Inc.	RFP	5.3.5	32	What is order of succession for MCO contracting if the selected MCOs bow out or don't qualify for a contract following the Readiness Review?	If a selected MCO bows out or doesn't pass the Readiness Review, the State can contract with the next best evaluated proposer and/or conduct another procurement.
30	Centene Corporation	RFP			Would the state consider allowing bidders to include an executive summary in their technical response?	An Executive Summary will not be reviewed and evaluated.
31	Volunteer State Health Plan	RFP Amendment #3, Attachment A	F.3.10	15	This question states "Current State policy allows only the State to recover the cost of the continuation of services furnished to the enrollee while the appeal was pending if the final resolution of the appeal upholds the MCO's or State's action." Under the new Risk Agreement, will at-risk MCOs not be allowed to recover funds when there are continued services (initially denied on appeal) and the final outcome of an appeal through the State Fair Hearing Process is an upheld denial?	Yes, if MCOs comply with guidelines developed by TennCare, they will be allowed to recover funds from enrollees when there are continued services and denial is upheld. The contract will be amended and further guidance on this will be provided after contract award.
32	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	1	1	The State fair hearing program is not listed in the definitions; please add definition.	The term is not used in the pro forma contract; therefore, the definition was not added. Refer to TennCare rules 1200-13-13-.11 and 1200-13-14-.11 and to 42 CFR 421, Subpart E (which defines the fair hearing process).
33	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	1	9	Can the Bureau confirm that the Medicare deductible and coinsurance are NOT included in benefits for dually eligible members?	The Medicare deductible and coinsurance are not included in benefits for dually eligible members who are TennCare Medicaid (as opposed to TennCare Standard) enrollees. If appropriate, TennCare pays the applicable Medicare deductible and coinsurance for TennCare Medicaid enrollees who are also Medicare beneficiaries.

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34	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.1.2	16	Does the Bureau contract with an external entity for the conduct of the Readiness Review? If yes, whom? Are the criteria/scoring for the review available now? Is there a corrective action program built into the review? What is the cure period? Would the Bureau allow a health plan to begin enrollment in one or more counties that have passed the review, while waiting for the corrective action review for a county that has not satisfied review standards?	The Bureau may elect to contract with an external entity for the conduct of the Readiness Review. The entity(ies) have not been determined. The criteria/scoring, timeframes and corrective action process for the review will be made available to the MCOs who are awarded a contract as a result of this procurement. However, the Bureau will not allow an MCO to begin enrollment in one or more counties that have passed the review, while waiting for corrective action review for a county that has not satisfied review standards. Pass/Fail will be determined on a Grand Region basis.
35	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.1.2	16	Please provide the anticipated completion date as well as scope (e.g. areas of focus) of the readiness review anticipated by TennCare.	TennCare anticipates that the readiness review will be completed at least one month prior to the start date of operations and will focus on all areas of operations.
36	John Deere	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.2	19	Please confirm whether current enrollees will have any choice of MCO and by what process or if the MCO assignment process will be done automatically by the Bureau.	As provided in Section 2.4.4.2, current TennCare enrollees will be assigned to MCOs in accordance with the auto assignment process described in Section 2.4.4.6. After a current TennCare enrollee has been assigned to an MCO, he/she will have one opportunity during the 45 day period after enrollment to change MCOs (refer to Section 2.4.7.2.1 of the pro forma contract).
37	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.3.2	20	Please confirm that this passage means that SSI enrollees will not participate in a 'voluntary enrollment' process?	Correct. Enrollment in an MCO is mandatory for SSI enrollees. SSI adults will be assigned by the State to an MCO (other than TennCare Select). SSI children will be assigned to TennCare Select but may opt-out of TennCare Select and choose another MCO.
38	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.6	20	Will the Bureau engage the services of an enrollment broker?	No.
39	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.6	20	Please provide specific details on how the auto-assignment process will work.	Refer to State's Response #42.
40	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.6.3	21	What is standard Medicaid eligibility period guarantee for TANF, SSI, duals beneficiaries in TN? Does a beneficiary's change in eligibility category necessitate disenrollment from the MCO? Will enrollees who experience eligibility category changes be automatically re enrolled into the original health plan?	There is no guaranteed period of eligibility for any TennCare enrollees. However, eligibility for most TennCare enrollees is redetermined annually. If a child's eligibility changes to SSI, then the child will be disenrolled from the MCO and enrolled in TennCare Select. For other enrollees, as long as they remain eligible for full benefits (not just Medicare cost-sharing), change in eligibility category will not necessitate disenrollment from the MCO. They will remain in the same MCO.
41	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.6.3	21	How will auto-assignment be handled, if a new MCO is awarded a contract currently held by one of the existing MCOs?	As provided in Section 2.4.4.6.3.4, enrollees will be assigned using default logic that randomly assigns enrollees to MCOs (other than TennCare Select).
42	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.6.3.4	21	Please define the logic mentioned in this reference. What does "randomly assigns enrollees" mean? Is this a 1:1 random distribution between health plans?	Yes. Enrollees are assigned to capitation rate categories based on eligibility category and age. Enrollees in each rate category are assigned to MCOs evenly on a random basis. If one MCO does not have sufficient capacity, it will get a proportional amount from each category that reflects its proportion of capacity to total enrollment. The State will try to preserve the ratios as evenly as possible; however, family cases will be enrolled in the same MCO.
43	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.4.6.4	21	What is the timing TennCare envisions for the application of quality metrics to the auto-assignment algorithm? Does TennCare have set metrics identified for application (i.e. encounter data submission, HEDIS/CAHPS scores, etc.)	TennCare has not determined the timing for the application of quality metrics to the auto-assignment algorithm but does not anticipate that quality metrics will be used during the first year of the contract. TennCare has not yet identified the quality metrics to be used.

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44	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.4.5.4	22	Will the Bureau consider reimbursing MCOs for the cost of care provided prior to an MCO being notified of a member's enrollment, given the fact that effective management of care and expenses is impossible prior to notification?	No. In addition, historical expenses associated with the provision of care provided prior to an MCO being notified are included in data used to develop the rate ranges.
45	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.7.2.2.1	23	Please confirm whether the 12 month lock-in for MCO enrollees will be defined by their effective date in the MCO or will the Bureau hold a common annual (date) open enrollment for all?	There is not a 12 month lock-in period per se. Members may change MCOs during the initial 45-day change period, based on hardship criteria, during the annual choice period, and as otherwise provided in the pro forma contract. The annual choice period is tied to the eligibility redetermination process; when individuals are redetermined eligible for TennCare they may change MCOs.
46	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.7.2.2	23	Is the time period for the Annual Choice Period the same for all members or a rolling period based on individual TennCare qualification dates?	The time period for the annual choice period is based on individual TennCare eligibility dates.
47	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.4.7.2.2.3	23	Is the hardship criteria described in this section comparable to federal standards re: for cause disenrollment?	Refer to TennCare rules 1200-13-13-.03(4)(b) and 1200-13-14-.03(4)(b).
48	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.6	27	The RFP does not specifically exclude Experimental or Investigative procedures, out-of-state services, out-of-country services or cosmetic procedures. Under what circumstances, if any, would these be covered benefits?	Section 2.6.10 provides that the MCO shall not pay for non-covered services as described in TennCare rules and regulations. Refer to TennCare rules 1200-13-13-.10 and 1200-13-14-.10.
49	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.2	27	Please clarify the terms and conditions under which the MCO must pay for all medically necessary services, without the benefit of diagnoses confirmation?	Section deleted. Refer to Section C of this amendment.
50	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.2	27	What does it mean when it states "the Contractor shall pay for medically necessary covered services regardless of the existence or absence of a specific diagnosis of the member"?	Refer to State's Response #49.
51	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	28	What is the status of the list of excluded benefits that was published earlier this year? Were there any changes in trend rates as a result of changes to the exclusion list?	The TennCare rules regarding exclusions were recently reissued. Refer to TennCare rules 1200-13-13-.10 and 1200-13-14-.10. Since the rule was clarifying current policy no changes were made to the trend rate as a result of changes to the rule.
52	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	29	Since the contractor is responsible for paying these claims, can we develop the formulary associated with it or any UM edits to control inappropriate utilization? Who handles the prior authorizations associated? Is the contractor responsible for developing the home infusion network?	Yes, the MCO may develop the formulary and manage utilization for the limited pharmacy services covered by the MCO. The MCO handles the prior authorizations associated with these services. Yes, the MCO is responsible for developing the home infusion network.
53	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	29	Newberry outlines 11 specific reasons where the MCO can not deny an authorization for services for home health or Private Duty Nursing services. Can home health/PDN services be denied: a. when the safety of the member is an issue, or b. when home health/PDN is not the most appropriate level of care c. can the services be modified or limited?	Within the next few months, TennCare intends to implement the definition of medical necessity found at TCA 71-5-144. Refer to Section QQ of this amendment for draft medical necessity rules which provide additional detail regarding the implementation of this new definition of medical necessity.
54	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	29	Must contractor strictly follow TENNCARE injectable drugs coverage or may additional injectables based on medical necessity be covered at plan's discretion?	No. Refer to Section D of this amendment.
55	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	29	In spite of the long term care carve out, the Newberry ruling creates a unintended incentive for enrollees and their families to migrate from inpatient long term settings to the home with PDN or to seek long term home care when there is no home bound status or need for skilled services. Why is long term home care/PDN not considered to be long term care and a part of the carve out?	Tennessee defines long term care to include institutions and HCBS waiver programs. Home care/PDN services are not considered long term care and are not part of the carve out.

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56	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	30	Has the State identified the transportation vendor that MCOs will be required to contract with?	No. The State intends to have a transportation broker by January 2007.
57	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	30	Some PDN is covered and is appropriate to have C.N.A. provide. Please comment regarding RN/LPN requirement.	Care that is appropriate to have a CNA provide would not qualify as PDN as TennCare defines the service. PDN is defined in federal regulations (42 CFR 440.80) and TennCare rules (1200-13-13-.01(80) and 1200-13-14-.01(79)) as services provided by an RN or a LPN.
58	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	30	Given that the contractor must use the state's vendor and pay state rates, how should transportation costs be included in the capitation rates?	For the purpose of this RFP the MCO should bid transportation costs as a component of its capitation rate. Under the requirements of the pro forma contract, the MCO will be financially responsible for the provision of transportation costs. When a transportation vendor is selected by the State, the Contractor must use the State's vendor and pay state rates. Refer to Sections E and U of this amendment. At such time, the capitation rates will be adjusted, if needed, in accordance with new Section 3.4.7 of the pro forma contract (refer to Section U of this amendment).
59	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.3	31	Organ transplants shall not be covered if they are experimental/investigation per Medicare guidelines. For all other services can Health Plans use experimental/investigational as reason not to cover a service? If so, what standards can Health Plan develop to assess whether something is experimental/investigational?	Per TennCare rules (refer to 1200-13-13-.10 and 1200-13-14-.10), experimental/investigational services are not covered. The MCO shall develop appropriate standards, in accordance with medical necessity rules, which shall be reviewed by TennCare. TennCare intends to issue medical necessity rules within the next few months. Refer to Section QQ of this amendment for draft medical necessity rules.
60	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4	32	Is the MCO required to enter the member into case/disease management when the limit is reached even if there is no additional coverage of the service?	The limits on non-pharmacy physical health services are "soft" limits. Once a member reaches the limit he/she is eligible for additional services based on medical necessity.
61	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4	32	Can the Bureau provide more clarity on the definition of soft limits?	TennCare believes that the language in the pro forma contract regarding soft limits is clear. TennCare will provide technical assistance in this area after contract award.
62	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4.2	32	Reference paragraph 2.6.1.4.2, what is the ability to not cover services over a service threshold?	Coverage of a service over a service threshold shall be based on medical necessity.
63	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4.2	32	How does TennCare define the difference between hard and soft benefit limits? Here, the 20 IP days and 8, 12, and 10 visits seem to be called soft limits. On page 83 of the Data Book, they seem to be called hard benefit limits.	They were originally set as hard limits and the cost impact was calculated. They were later re-defined as soft limits and it was assumed that the State would only realize 20% of the original amount.
64	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4.2	32	Does referring to the benefit limits in this section as "soft limits/service thresholds" mean that services provided beyond those limits are allowable costs, for purposes of claims experience reporting and assessing actuarial soundness? [Financial folks - is there a better way to clarify what is meant by "allowable costs" in TN?]	Yes, medically necessary services provided beyond the soft limits/service thresholds are allowable costs.
65	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4.2	32	Does referring to the benefit limits in this section as "soft limits/service thresholds" mean that a claim paid for services beyond the soft limits/service thresholds is accurately paid for purposes of auditing the accuracy of claims payment against "hard benefit limits," as referred to in provisions such as 2.22.6.4.10?	The "hard" benefit limit refers to the limits on substance abuse services (see Section 2.6.1.5), not to the "soft" limits in Section 2.6.1.4 of the pro forma contract.
66	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4.2	32	Given that the limits in this section are designated as "soft limits/service thresholds," please specify what TennCare's "hard benefit limits" are and where they are described.	Refer to State's Response #65 and #163.

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67	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.6.1.4.3	33	Please describe basis for setting the quantities pertaining to the soft limits. If an MCO reviews each inpatient admission for CM/DM potential, please justify need to automatically place in CM/DM. Some acute admissions are not appropriate for continued CM/DM. Also, do ER visits count toward limit of outpatient hospital? Do lab and x-ray administered under the BHO count toward medical limits?	Instead of implementing hard limits, the State decided to use soft limits. The soft limits are based on the hard limits that were to go into effect July 1 of this year. A member shall be enrolled in CM/DM once he/she exceeds the 20 day limit for inpatient hospital services. Yes, ER visits count toward the outpatient hospital limit. The specifics on the counting methodology, including the approach to behavioral health services, will be provided after contract award. Refer to State Response #377.
68	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.3	34	There has been a recent court decision regarding Medical Necessity. Can you clarify what the court order means with regard to the definition of medical necessity in TennCare, and the procedure required for MCOs to make medical necessity determinations?	Within the next few months, TennCare intends to promulgate medical necessity rules. Refer to Section QQ of this amendment for draft medical necessity rules.
69	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.3	34	If the MCO makes a decision based on medical necessity and for a child under 21 years of age, is the MCO going to be directed to pay for not medically necessary services when we are at risk?	All services to children under 21 years of age, other than TENNderCare screens and interperiodic screens, must be medically necessary in order to be covered.
70	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.6.5	35	Does the Bureau mean that the process whereby an MCO uses alternative services requires their prior approval or does every case where alternative services will be used require their prior approval?	Unless otherwise authorized by TennCare policy, any cost effective alternative service must be prior approved in writing by TennCare. However, TennCare approval is not required for every case where the approved cost effective alternative service is used.
71	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.6	35	Is the selected MCO allowed to offer any value-added enhancements to the TennCare benefits for OTC, Dental, or vision? Are we allowed to offer non medical enhancements that promote healthy living, such as free memberships to the YMCA or Boys and Girls Clubs?	TennCare maintains a list of CMS approved services that MCOs may elect to provide, at their sole discretion, as cost effective alternative services. The services on this list are not otherwise TennCare covered services. The MCO may elect to offer these services as provided in Section 2.6.5 of the pro forma contract. These services are not considered "additional services" referred to in Section 4.5 of the RFP; these services shall be provided under the MCO's capitation payment rates. The proposer shall not propose any additional cost for cost effective alternative services.
72	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.7.4.1.1	36	These sections require that if an enrollee requests a non-covered service, the provider must obtain a written acknowledgement that the service is not covered prior to rendering the service. It goes on to say that if the provider bills the MCO for the non-covered service, any prior arrangement for payment between the provider and the enrollee becomes null and void.	No question so unable to respond.
73	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.6.7.4.1.4	36	Please specify which TennCare rules and regulations TennCare considers to be applicable to providers here and that they must comply with in order to seek payment from a member if services are not covered because they are in excess of the member's hard benefit limit.	Refer to TennCare rules 1200-13-13-.08(5)(b) and 1200-13-14-.08(5)(b).
74	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.6.3	40	Please clarify the differences with a Level 1 CM encounter from a Level 2 CM encounter.	Refer to Attachment I of the pro forma contract for the clinical criteria. The State will identify modifiers to be used to distinguish between the two levels of case management.
75	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.8.1.1	41	Please explain why the state intends to manage its own crisis telephone system (linked to the Contractor's contracted crisis teams) instead of allowing the Contractor to manage that crisis line internally?	Since behavioral health crisis services are available to any person who needs them, the State will manage the crisis line to ensure that there is one line equally available to all individuals in the State, regardless of MCO enrollment or county of residence. (The State will pay providers for behavioral health crisis services to individuals not enrolled in an MCO.)

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76	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.8.1.1	41	Please describe the State's toll free number and how it will link/interface with crisis service teams. How will the Contractors link their crisis teams to the trained crisis specialists handling the statewide crisis line and crisis dispatch?	Calls to the crisis line will be routed through an automated system to a crisis team serving the area where the individual is located. Thus, the crisis line will be answered by the crisis teams, which will be MCO contract providers. The State will not have a separate crisis specialist handling the calls.
77	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.8.1.1	41	Please clarify that the State will provide the crisis line but the Contractor is to insure the state's line is linked to a crisis team.	Correct. The State will provide the crisis line but the MCO shall ensure that the crisis line is linked to an appropriate crisis team that is adequately staffed to render services.
78	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.8.1.5	41	Can the crisis unit also be the mandatory pre-screening agent (MPA) prior to an involuntary admission?	Yes, crisis service providers may be MPAs if they meet the criteria for a MPA and are designated as an MPA.
79	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.10	42	Do court orders re: treatment for Judicials specify providers to be utilized? If yes, how does the Bureau intend for plans to coordinate with out of network providers for Judicials? What kind of reporting is required from MCOs re: enrollees under court ordered treatment? Do MCOs receive copies of court orders from the courts or are we reliant on the Member to communicate orders?	Sometimes the court order specifies the provider. If it does, the MCO can either go back to the court and request that the order be modified (e.g., to specify a contract provider) or can enter into a single case agreement with the specified provider. There is no reporting specific to individuals receiving court ordered treatment. MCOs will typically receive orders from the provider or the court, not the individual.
80	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.10.2.1	42	Are court ordered behavioral health services included in the utilization/data contained in Attachment 6.8?	Yes. They are included under the State Only and Judicial classifications.
81	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.7.2.11.1	43	Does the Bureau intend that the MCO cover outpatient treatment for all those who are involuntarily committed through the criminal justice system regardless of whether the person meets the income eligibility criteria? In addition, is this requirement consistent with the general understanding that persons who are committed as a result of criminal proceedings are usually deemed ineligible for Medicaid coverage? Please explain the rate assumptions and reimbursement mechanism for such individuals.	The criminal justice system requires mandatory outpatient treatment (MOT) of persons following an inpatient adjudication and evaluation after being deemed not guilty by reason of insanity (NGRI). There are no income eligibility criteria for persons requiring services through MOT. The MCO shall cover MOT for TennCare enrollees and for State Onlys and Judicials. Historical costs are reflected in the data book.
82	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.7.3	43	Please provide clarification on the classification of health education & outreach materials. Will they be considered medical or administrative?	Administrative.
83	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.7.5.1.8	46	Consider adding verbiage to allow referral tracking based on utilization of specialist services.	This is permitted by the current language. No change.
84	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.7.5.4.8	53	#12 - Does DBM cover dentures for enrollees?	The DBM covers dentures for members under age 21 pursuant to TENNderCare requirements.
85	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.7.5.4.8	55	Consider adding the comments in #17 to top of #13 "The MCOs are not required to contract with following providers if the services are available through other contract providers."	Reference not clear; unable to respond.
86	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.2.4	64	"The contractor shall ensure that the member is held harmless by the provider for the costs of…" Is this applicable to non-participating providers?	Yes.
87	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.3.2.6.8	65	Is the Contractor responsible for psychiatric inpatient care in a state-owned facility?	Yes, the Contractor is responsible for medically necessary psychiatric inpatient care, including care in state-operated Regional Mental Health Institutes (RMHIs).
88	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.3.2.6.8	65	What is the limit of responsibility where the Developmental Disorder is the primary diagnosis for the admission and the Psychiatric diagnosis is the secondary diagnosis?	The MCO shall provided covered services as medically necessary.
89	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.4.6	66	What format will this data be in? (i.e. NCPDP vs. proprietary) and how often will the data be received?	TennCare anticipates that the data will be provided on a weekly basis in modified NCPDP format.
90	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.4.6	66	How often will we receive PBM data and how current?	TennCare anticipates that the data will be provided on a weekly basis with data from the previous 7 days.
91	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.9.6.3.2	69	Please clarify what is considered an appropriate placement for a psychiatric hospital discharge.	An appropriate placement is one that is at least comparable to the one the individual had prior to the inpatient service and meets the clinical needs of the person.

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92	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.7	69	Given that the Contractor is expected to conduct a high level of coordination with the PBM and monitor utilization, how are these services accounted for in rates?	The administrative load of 9% accounts for coordination of services to be provided by the Contractor, including coordination with the PBM and monitoring utilization.
93	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.9.7	69	How will the Bureau arrange to have Member prescription info, critical to the case management process, shared with the MCOs?	Refer to State's Response #89 and #90.
94	John Deere	RFP Att. 6.1 (Pro Forma Contract)	2.9.7	69	TennCare has had difficulty in recent past providing timely and accurate pharmacy data. What provisions will be made to an MCO at risk if timely and accurate data cannot be provided?	TennCare is currently providing and will continue to provide timely and accurate pharmacy data (refer to State's Response #89 and #90).
95	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.9.7.2	69	Please specify the format of drug data or add "mutually acceptable format".	Refer to State's Response #89.
96	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.7.4.2	70	Please identify/define the “peer norms as defined by TennCare.” Are they based on national industry standards/guidelines? How often do they change?	This will depend on the review. TennCare generally reviews prescribing patterns for a particular type of drug, e.g., narcotics, and identifies providers that appear to be outside the norm for other physicians in Tennessee.
97	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.9.8.1.3	70	Are copies of the Bureau's contracts with the DBM and PBM available to MCOs for review/coordination?	Yes, the contracts are available on TennCare's website at http://www.state.tn.us/tenncare/healthplans/RFI/PBM-DBM.html.
98	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.9.8.1.3	70	Is the relationship between the Bureau, MCOs and the Bureau's vendors considered an OHCA under HIPAA Privacy Rules? Is the execution of BAAs necessary?	No, the relationship is not considered an OHCA. Execution of a BAA between the MCO and the State is not necessary because BAA requirements/assurances are incorporated in the pro forma contract.
99	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.9.9.1	75	Will the Bureau or MCOs have access to the Medicare Common Working File?	CMS does not allow states and their contractors to have online access to the complete CWF (Medicare Data Base). However, the State does have other sources of Medicare enrollment and claims data, and TennCare provides Medicare data to MCOs, e.g., to coordinate benefits with Medicare.
100	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.10.2	76	Are there any other services excluded from the per diem rate besides prosthetics, some DME items, non-emergency ambulance transportation, and non-emergency transportation that are the responsibility of the MCOs?	Yes, there are other services excluded from the per diem, e.g., emergency transportation and medical care by a member's own physician. After contract award TennCare will provide technical assistance to more precisely identify the responsibilities of the MCO versus the institution.
101	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.10.2	76	What are the "some DME items" that are excluded from the per diem rate? Can you provide us with a list of the HCPCS codes that represent these items?	The per diem includes general DME that the member will need within the facility. Excluded DME items include, e.g., specialized DME. After contract award TennCare will work with the MCOs to identify the DME items that are covered by the MCO.
102	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.10.2	76	How will we be able to identify these members in the enrollment file so that the MCOs know which services to pay for and which to deny back to the providers for TennCare to cover?	The enrollment file includes an indicator that identifies members who are "institutionalized" (receiving institutional or HCBS waiver services).
103	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.9.10.2	76	How are the services "excluded from the per diem rate" billed? By physicians or by facilities? On a CMS-1500 or CMS-1450?	The services are billed by physicians or other providers using the applicable billing form.
104	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.11	77	To ensure maximum network participation in the TennCare program, encourage providers to responsibly negotiate and contract with the chosen MCOs, and to ensure a fiscally sound reimbursement schedule, we highly recommend the State mandate a non-participating provider and out-of-network provider reimbursement rate that is less than 100% of the current Medicaid Fee Schedule. This approach has proven successful for the State of Georgia, which is currently implementing its new Medicaid program. The Georgia Department of Community Health requires that out-of-network providers are reimbursed at 90% of the Medicaid Fee Schedule.	Payment of non-contract providers is governed by TennCare rules. Refer to rules 1200-13-13-.08 and 1200-13-14-.08.

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105	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.11.1.6	78	Will the State provide periodic files or electronic listings of the Medicaid numbers for current providers for the MCO verification?	This information will be provided to the MCOs upon request.
106	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.11.1.6	78	Including Medicaid provider numbers will have a large impact for non-par providers outside of the state of Tennessee. Consider requiring for only par providers.	TennCare requires all providers, including non-par providers, to have a Medicaid provider number. TennCare will provide technical assistance on this requirement after contract award.
107	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.11.1.6	78	Are all behavioral health providers required to have Medicaid #'s in order to participate in the Contractor's provider network? Currently non-licensed providers such as case managers and peer specialists are not required to have Medicaid numbers. What information and process will be required to obtain the number?	Currently, and under this procurement, behavioral health providers are required to have a Medicaid provider number. Non-licensed providers such as case managers and peer specialists are not required to have Medicaid provider numbers because they are employed by an agency that has a Medicaid provider number.
108	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.11.1.7	78	Does this denial apply to dual eligible members if MCO has a participating provider within member's area?	Section 2.11.1.7 of the pro forma contract applies to all members, including dual eligible members. Refer also to TennCare rules 1200-13-13-.10 (3)(b)80 and 1200-13-14-.10(3)(b)80.
109	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.11.3.4	82	Section 2.11.3.4 requires the Contractor to include in its network the Weight Watchers regional center. What benefits and services are to be covered at this provider? Benefit limitations for this provider?	Eligible members may attend weekly Weight Watchers meetings once a week for 12 weeks. Members who attend at least 10 weekly meetings in the 12 week period and meet other criteria may participate in an additional 12 week program. Coverage includes additional 12 week programs as long as the member meets the applicable criteria. Participation in Weight Watchers meetings is the service that may be covered as a cost effective alternative service. Weight Watchers food and other products may not covered.
110	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.11.5.1	83	In diverting new admissions to other inpatient facilities away from RMHIs, will the State divert State Onlys and Judicials?	New admissions can be diverted to any facility authorized by the State to receive State Onlys or Judicials, as applicable.
111	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.11.7.2	84	Are MCOs required to credential providers with whom they enter into single-case agreements with? Based on the potential volume of work this represents, we recommend that this requirement not apply to those providers with whom the MCO has negotiated a single-case agreement.	Per NCQA standards, if an independent relationship exists, then the MCO must credential the provider.
112	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.11.8.1	85	Will the Bureau please provide a copy of the referenced member notice templates?	TennCare will provide these templates after contract award.
113	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.11.8.1.4	86	Consider adding time frame, such as 'written notice to member who have been patients of the non-PCP provider, within the last twelve months.' This is an acceptable NCQA timeframe.	No change; necessary to meet requirements under Grier.
114	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.11.8.1.5	86	If an MCO is required to notify its members of a network deficiency pursuant to this section, are members given the opportunity to disenroll from the MCO?	Not as part of the notice process. However, the member may request disenrollment based on hardship or there may be an intermediate sanction that includes disenrolling members.
115	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.11.8.2.3.1	86	Propose 10-30 days notice instead of 5 unless termination materially impacts TennCare network.	No change to requirement. Note that notice is required within five days of the date the member notice was sent.
116	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.12; 2.26.1.5	87, 163	Is a subcontract between the Contractor and a managed behavioral health subcontractor that *arranges* managed behavioral health services, but is *not* a provider, required to include all terms specified in Sec. 2.12.7.1 – 2.12.7.51, in addition to the terms required by Sec. 2.26?	It depends on the contracting relationship between the MCO and the subcontractor as well as the specific functions of the subcontractor.

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117	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.12.3	87	We strongly object to the clause that the Contractor will revise provider agreements as directed by TennCare. Section 2.12.7.34 already incorporates all "state and federal laws, regulations and guidelines applicable to the CONTRACTOR and the provider. Provide that the agreement incorporates by reference all applicable federal law and state laws, TennCare rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the provider agreement, as they become effective;" All appropriate linkage into the MCOs contracts exists in 2.12.7.34. Section 2.12.3 would allow the Bureau an inappropriate level of access to private companies' proprietary contracts allowing for unilateral adjustments on behalf of the State without the agreement of either the MCO or the provider.	This is a current contract requirement. If the State determines that a provider agreement does not comply with the applicable requirements, the MCO shall revise the agreement to comply with the applicable requirements.
118	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.12.4	87	Suggest that this requirement be deleted if the MCO is operating under option 3.	Regardless of whether the MCO is at full risk, TennCare has an interest in limiting the use of non-contract providers.
119	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.13.1.1	94	The pro-forma contract states, “The Contractor must agree to reasonable reimbursement standards to providers for covered services, to be determined in conjunction with actuarially sound rate setting. All reimbursement paid by the Contractor to any other entity is subject to audit by the State.” Can you please clarify what “reasonable reimbursement standards to providers for covered services” means, as well as what you mean by actuarial rate setting?	This language means that the Contractor's reimbursement rates must be reasonable in light of the capitation payment rates proposed by the MCO and certified by the MCO's actuary. For example, reimbursement of all providers at billed charges would not be considered reasonable.
120	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.13.2	94	Does this payment apply to the Medicaid rate?	Refer to Section F of this amendment. This is the amount the MCO must pay providers in the specified circumstance.
121	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.13.3.1	94	According to this section, the reimbursement rate for behavioral health mobile crisis teams, as set by the state, will be factored into the Contractor’s capitation payments. Currently, the RFP data book indicates that mobile crisis team compensation is included in the grant line items for NPMH and PMH. Will the Contractor receive an adjustment in the capitated rate for grants for both NPMH and PMH? If the adjustment is not intended to be in the grants service category, please identify the service category(ies) to be adjusted and indicate whether the adjustment is an add-on or other. How will the Contractor be made aware of the adjustment? What is the timeframe for receipt of this information?	80% of the crisis costs have been included in the capitation rates. The remaining 20% will be funded by the State. Any adjustments to these rates will flow through to the MCOs accordingly.
122	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.13.8.2	97	Given that the plan will not know at the time of adjudication that the provider did not know the member belonged to the MCO, how does the state envision this working?	The MCO will know this because the enrollment file includes the date the member was added as well as the member's date of eligibility.
123	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.13.9	97	Can MCO require the referral/authorization process to still occur?	The question does not provide sufficient information for us to respond.
124	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.13.11.1	97	Should the last line of this section say "provided by a Medicare contract provider" instead of just "provided by a contract provider"?	No.
125	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.14.1.10.1	100	Clarify requirement and consider eliminating specific requirement if MCO is operating under option 3.	Refer to Section G of this amendment. The revised requirement applies regardless of risk option.
126	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.14.1.10.5	100	Clarify requirement and consider eliminating specific requirement if MCO is operating under option 3.	Refer to Section H of this amendment. Revised requirement applies regardless of risk option.
127	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.14.1.11.1	101	Clarify requirement and define process if MCO is operating under option 3.	Current requirement; no change.

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128	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.14.1.11.2	101	An ER Threshold is mentioned but not listed in the Service Thresholds section 2.6.1.4.2. What is the threshold of ED visits defined by TENNCARE?	The ER threshold is not the same as the soft limits in 2.6.1.4.2. It is determined by TennCare every six months.
129	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.14.3.5.1	103	This section states that the Contractor is to provide a hard copy listing of referral providers at least 30 days prior to go-live followed by quarterly updates. Can we provide this listing via our Website?	The MCO must provide a hard copy listing in addition to providing it on its website. TennCare needs documentation that providers received the listing.
130	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.14.3.5.1	103	This section requires MCOs to mail updated referral directories to all PCPs on a quarterly basis. We recommend you revise this requirement to allow for web-site posting of updated referral directories in lieu of mailing hard copy directories to PCPs, with a requirement that the MCO provide a printed copy to any provider upon request.	Refer to State's Response #129.
131	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.14.3.5.2	103	Since list is distributed only to provider offices and directory does not contain all information currently distributed to providers, suggest that alternative format be allowed.	The listing must include, at a minimum, the information required for the provider directory. It may include additional information.
132	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.14.4.1	103	While the CRA defines post-stabilization services consistent with the federal regulations, 42 CFR 438.114(e), section 2.14.4.1 appears to prohibit any prior authorization requirement for such services, a utilization management tool expressly permitted in the federal regulation. What rate assumptions have been made to address this apparent prohibition of an otherwise widely accepted utilization management protocol?	The State did not intend to be more restrictive than federal requirements. Refer to Section I of this amendment.
133	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.14.5	104	Suggest that this requirement be deleted if the MCO is operating under option 3.	No change. PCP profiling is required of all MCOs, regardless of risk option.
134	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.15.1.3	105	Please provide intent or clarification of this requirement.	See NCQA Standard QI 2, Element D.
135	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.16	109	Why did the Bureau choose to restrict marketing activity? Regarding the limit on marketing, please explain how the chosen MCOs will communicate information to potential members about their health plans? Will the enrollment broker distribute information about the health plan? Is any MCO advertising allowed (such as radio ads, billboards, and the like)? Will MCOs be allowed to have community outreach representatives that can speak to eligibles about the TennCare program and the MCO in public locations?	In the past TennCare has had negative experiences with marketing, and there is concern that marketing expenses divert funds from providing services. MCOs will communicate information to potential members through the state and may communicate directly with its members. MCOs are not allowed to conduct any advertising regarding their TennCare product. The MCO may not have representatives speak to eligibles about its TennCare product.
136	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.15.6.3	109	Please note the typo in the last sentence. It currently reads “3”, but should be “30”.	Agree. Refer to Section J of this amendment.
137	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.17.1.1	110	Please confirm that the Bureau interprets this section to mean that it has the authority to only review materials for its members and that it does not have the authority to review materials for dual enrollees, CMS holds the authority for those reviews since they solely deal with Medicare issues.	TennCare has authority to review materials provided by the MCO as a TennCare contractor to TennCare members, including duals. Materials provided by the MCO as a Medicare Advantage Plan to Medicare enrollees, including duals, are not covered by this contract.
138	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.17.1.2	110	Which electronic file formats are acceptable for submission of member materials for approval? Are .pdf files acceptable?	The file format will depend on the type of material. In general, TennCare requires a MS Word version in order to verify grade level as well as a PDF file.
139	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.17.2.3	111	Please note the typo in reference to additional contract section. It appears that the reference should be to Section 4.32.	Reference corrected. Refer to Section K of this amendment.
140	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.17.2.3	111	Are MCOs required to include a non-discrimination assurance on all materials, including standard member letters, outreach materials, etc.?	Yes.

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141	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.17.2.3	111	Do you mean 4.32.1?	Yes. Refer to State's Response #139.
142	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.17.2.5	111	What other Limited English Proficiency groups require translation services (in addition to Spanish)?	Currently the only Limited English Proficiency group is Spanish. Note that the MCO must provide oral interpretation services in all non-English languages, not just Spanish.
143	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.17.2.5	111	In addition to the required Spanish translation, please identify additional language limited proficiency groups.	Refer to State's Response #142.
144	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.17.2.6	111	Are MCOs required to include translation services language on all materials, including standard member letters, etc?	Yes.
145	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.17.2.7	111	Define "alternative formats".	This refers to the Medicaid managed care requirement in 42 CFR 438.10. Alternative formats include but are not limited to Braille, audio cassette, large print, CD-ROM, and human readers.
146	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.17.4.1	112	Can the State please provide a copy of the member handbook template?	The existing template is designed for the current MCO contract. Given the differences between the current MCO contract and the pro forma contract, in particular the integration of behavioral health, this template is not applicable to the pro forma contract and could cause confusion.
147	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.17.4.1	112	The Contractor Risk Agreement mentions a TennCare member handbook template to be utilized as the base for development of our member handbook. Where can this template be located on the state's website?	The template is not available on the State's website. Refer to State's Response #146.
148	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.17.4.1	112	Consider changing "immediately distribute" to say "within 30 days".	No change.
149	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.17.4.2	112	Does the Bureau require issuance of member handbooks annually, if there are no material changes? Please clarify that the Bureau does not require the issuance of new member materials to enrollees who have changed program eligibility categories and remain or are re-enrolled in the health plan within a specified period (i.e. 30 days).	Yes, TennCare requires issuance of member handbooks annually. In general, TennCare does not require issuance of new member materials to enrollees who have changed program eligibility categories. However, if this changes their eligibility from Medicaid to Standard, then the MCO must issue a new member identification card and materials explaining the change. Member materials must be sent to members who are re-enrolled after losing eligibility for a temporary period.
150	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.17.4.2	112	Consider changing "immediately distribute" to say "within 30 days".	No change.
151	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.18.1.9.1	118	We would like to have "nurse triage/nurse advice line or queue" verbiage removed from this requirement. This service is provided and tracked separately than Customer Service lines.	No change. Providing and tracking a nurse triage/nurse advice line separately is permitted by the language in the pro forma contract.
152	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.18.4.8.1 (Attachment VII #4 & #6)	119	While we agree standards and service levels need to meet customer expectations, these standards are not measured by NCQA and we suggest further review and no liquidated damages for not achieving.	The performance standards for UM line/queue references NCQA in the event there is an applicable benchmark. Otherwise, the benchmark specified is applicable.
153	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.19.2.6	124	This question states that "the CONTRACTOR shall have the ability to take telephone appeals..." Currently, all member appeals are routed to the TennCare Solutions Unit. With this contract, will that process change? Will MCOs be required to take member appeals directly?	The current process will continue.
154	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.19.2.18	125	Is this binding "state-level review" the same thing as a binding Directive or ALJ Order regarding a member appeal case? If not, how are these different?	Section deleted. Refer to Section L of this amendment.

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155	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.20.2.4	126	Section 2.20.2.4 on Fraud and Abuse prohibits the MCO from taking any action to recoup moneys owed by a provider that is being investigated by the State for fraud. This language is problematic for those MCOs that also have commercial operations given that they may well be required by their commercial contracts to recoup moneys from these same providers for other agreements. It was our understanding that this would be corrected in the existing CRA provisions this Summer. Does the TennCare Bureau intend to correct or amend this language to deal with this issue?	This was addressed in the pro forma contract. Refer to language in Section 2.20.2.4 applying the prohibitions to actions that "specifically relate to TennCare claims" as well as creating a procedure for prior approval to take the otherwise prohibited actions. This language was developed based on comments from current MCOs and was agreed to by all of the current MCOs.
156	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.20.2.4-2.20.2.6	126	The CRA requires that the MCO conduct a preliminary investigation of all suspected incidents of fraud and abuse, yet precludes any communication with the provider regarding the matter. As the initial step in any investigation is generally a request for medical records, how can the MCO conduct the preliminary investigation without contacting the provider's office to request the records?	The prohibited actions apply after the MCO has reported the fraud/abuse and thus after the preliminary investigation.
157	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.21	128	When MCOs were at risk a minimum loss ratio law was passed. Is this still in place and if so how does it affect the bid?	No. Currently, there is no such requirement.
158	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.21.2.3.2	129	Could you provide more detail regarding the process and timing of this approval?	See RFP Attachment 6.1, Section 3.11.7.
159	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.21.2.3.5	129	Could you provide more detail regarding the timing of this approval and any specific requirement for this process and approval?	See RFP Attachment 6.1, Section 3.11.7.
160	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.21.4.10	131	Explain what assistance will be expected for identifying enrollees with another insurance.	The requirement for Contractor's with non-TennCare lines of business to provide assistance identifying enrollees with another insurance is in the TennCare Contractor Risk Agreement that TennCare MCOs operate under today. The required minimum data elements include: enrollee's name, enrollee's SSN, enrollee's date of birth, enrollee's group insurance number, policy limitations, policy benefits, beginning effective date of enrollee coverage, ending effective date of enrollee coverage, name of insured policy holder, social security number of insured policyholder, and type of insurance coverage (e.g., employer, individual, etc.).
161	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.21.5.1.1.2	131	Is there additional information for the calculation/percentage regarding any revenue above $150,000,000?	No. Questions related to the calculation of net worth should be directed to the Tennessee Department of Commerce and Insurance.
162	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.21.5.5	133	Does the restricted deposit (Section 2.21.5.3) count as a liquid asset for the Liquidity Ratio calculation?	As specified in RFP Attachment 6.1, Section 2.21.5.5, admitted assets include cash, cash equivalents, short-term investments and bonds, which would include the restricted deposited required in RFP Attachment 6.1, Section 2.21.5.3.
163	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.22	136 to 142	References are made to "hard benefits" but there is no definition of hard benefits. Please clarify.	The "hard" benefit limits in the pro forma contract are the day limit for detoxification and the lifetime limit on substance abuse benefits for adults (see Section 2.6.1.5).
164	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.22.3.1	137	Regarding standardized paper billing forms/formats: The new CMS 1500 goes into effect 10/1/06; and the new UB-04 goes into effect 3/1/07 – will the contractor be required to receive these forms under this contract? If yes; since both these forms support the HIPAA National Provider ID (NPI); is it an RFP contract requirement that all providers have an NPI? We know, per Attachment IX, Exhibit E; that the NPI is listed as an element; but our question is: - is an NPI required of network providers in this program? NOTE: HIPAA does not require NPI to be used on paper claim submissions.	Yes, per Section 2.22.3.1 of the pro forma contract, the Contractor shall comply with all standardized paper billing forms/formats and updates. Yes, an NPI is a requirement for MCO providers.

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165	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.22.4.2 2.22.4.3	138	For the reporting of these measures, we would like to confirm that we can combine all of our TennCare business, not segregate by region. We will not manage these claims differently by region.	The reporting of these measures can be submitted to TennCare as a single electronic file. However, the reporting of these measures shall be segregated by region; this segregation is especially important for contract compliance and performance monitoring purposes in circumstances where an MCO is operating under separate agreements in different regions.
166	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.22.6	139	For these audit procedures, we would like to confirm that we can combine all of our TennCare business, not segregate by region. We will not manage these claims differently by region.	The reporting of these measures can be submitted to TennCare as a single electronic file. However, the reporting of these measures shall be segregated by region; this segregation is especially important for contract compliance and performance monitoring purposes in circumstances where an MCO is operating under separate agreements in different regions.
167	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.22.8.2	141	What is the State's definition of "sensitive services"?	Sensitive services are identified using ICD-9 codes. The list of codes will be provided after contract award.
168	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.22.13.2	142	How will the Bureau notify an MCO that a provider is on “payment hold?” As an MCO is required to adjudicate all provider claims within the prompt pay timeframes, can the MCO inform the provider that the Bureau has placed the provider on “payment hold?”	TennCare sends MCOs a list of excluded providers. Yes, the MCO can inform the provider that the Bureau has placed the provider on "payment hold".
169	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.23.1.6	144	Regarding the statement: *The systems refresh plan will also indicate how the CONTRACTOR will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component*. What if a “system component” is wholly owned/developed, and maintained by the Contractor itself? In this case, our assumption is that this requirement calls for an attestation of support by the Contractor, correct?	Yes, with an indication of who from the Contractor's staff is providing said support and how it ensures said staff is adequate and properly trained and equipped at all times.
170	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.2.1.1	144	If the contractor is required to conform to the data and document management standards detailed in the HIPAA Implementation and TennCare Companion Guides, would the State make the documents used by TennCare available for review during the procurement process?	This reference material is available on TennCare's website.
171	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.2.3.3	144	Does this requirement apply to documents that were generated electronically for mass mailings?	Yes.
172	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.2.3.3	144	If this requirement applies to mailings other than electronic mailings, the contractor would be able to supply the date of the mailing, but not necessarily the time. Would the State consider rewording this requirement to clarify what documents require such detailed tracking?	The requirement only covers electronic mailings.
173	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.2.3.3	144	Do you need an actual listing of all members and providers that were sent a particular document? Do you also need a sample of the particular document referenced in the first question?	Yes to both, upon request.
174	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.2.4.3	145	24 hour turn around on information requests for 3 - 6 year old data is very tight. Consider making turnaround time 72 hours.	The turnaround time requirement was revised. Refer to Section M of this amendment.
175	John Deere	RFP Att. 6.1 (Pro Forma Contract)	2.23.2.4.3 and 2.23.6.4.6	145, 150	Please clarify the apparent two different file retention and retrieval periods between requirement 2.23.2.4.3 and requirement 2.23.6.4.6.	The requirement in Section 2.23.6.4.6 is specific to information "audit trails" as described in the contract. The requirements in Section 2.23.2.4 apply to information used by the MCO to conduct its business as part of the TennCare program. Thus, they are two distinct requirements. Refer also to State's Response #174.

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176	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.23.2.5	145	Please acknowledge that the MCO's obligation to disclose such information is allowable where required by law e.g. upon receipt of a valid subpoena.	The requirement in this section applies to state requests for information including but not limited to those tied to a subpoena.
177	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.23.3	145	A general question: Can the State/TENNCARE supply us with Data Layouts for at least the major data exchanges? – Specifically: Daily Enrollment File from TENNCARE to Contractor; Enrollment updates from Contractor to TENNCARE; Encounter extracts from Contractor to TENNCARE. If these and other formats are available on the web – could you supply exact URL and version we should examine? The reason that we ask for this material – is to afford you a better, more accurate & realistically priced proposal.	This reference material is available on TennCare's website.
178	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.3.3	146	Are there any immediate requirements for an MCO to provide Web pages that will be accessible from the TENNCARE/State Website/Portal? If so, what are they? And are there any web requirements planned for the member to have access to any information on a plan-specific website?	Yes, the MCO must provide a link to its home page to be included on the TennCare website. While there are currently no requirements for members to have access to information on a plan-specific website, the current MCOs provide access to member and provider information on their websites, and this would be expected under the Middle Tennessee contract.
179	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.23.3.3	146	Please provide the specifications for the website in order to evaluate the level of integration needed.	Reference materials related to the State's and TennCare's websites are available at: http://www.state.tn.us/finance/oir/pol1.html. Refer to State's Response #178.
180	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.4	146	Has a definitive testing schedule been established for encounter data (HIPAA 837 transaction file), based on the revised 4/1/07 program start date?	The testing schedule will be provided after contract award.
181	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.4.1	146	Will the HIPAA 820 Premium Payment transaction be used as an avenue to provide premium payment information to the MCO?	Yes.
182	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.4.1	146	Will the HIPAA 835 Remittance Advice transaction be used as a response to indicate the status of encounter data?	It is not the method used at present.
183	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.4.2.2	147	From our experience with the submission of quality encounter data for our other state clients, it is extremely difficulty to ensure that 90% of reported errors with encounter data are addressed within 30 calendar days and 99% are addressed within 60 calendar days. Would the State consider revising this standard to read: "A minimum of 95% of the encounter data submitted to TennCare must successfully pass all encounter edits within the first 6 months of submission, with 97% passing all edits thereafter"?	The standards in the contract related to these processes will not be revised.
184	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.4.3	148	Current processes do not support sending encounter data to TennCare within 48 hours from end of a payment cycle. (Time to transfer to warehouse, then data extraction/processing, etc). Consider change to timeline to 'within 5 business days'.	The standards in the contract related to these processes will not be revised.
185	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.4.3.1	148	How is a “payment cycle” defined by TennCare as it relates to the timeliness of reporting encounter data to the State?	The State assumes that MCOs will issue payments according to a set periodicity (e.g. "Thursday of each week"), i.e. payment cycle.

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186	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.4.3.1 and 2.30.16.2	148, 183	The Contractor is required to submit encounter data within 48 hours after the end of a payment cycle and submit encounter data on a weekly basis. Our current processes for other markets include payment cycles twice a week and the submission of encounter data monthly. This process is comprehensive and ensures we supply our clients with the quality encounter data on the first submission. If Contractors submit encounter data on a weekly basis and within 48 hours of a payment cycle, they will not have adequate time to prepare data in a quality manner and we would not have sufficient time to collect encounter data from third party vendors. Would the State consider changing these requirements to monthly submissions?	The standards in the contract related to these processes will not be revised. Note: per Section 2.23.4.3.1, if an MCO runs two payment cycles in a week it shall be expected to generate two encounter data files to TennCare, i.e. one file at the end of each payment cycle run during that week.
187	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.5	149	Please provide the date by which the State will provide an HIPAA 834 Enrollment transaction file for testing. Also, please provide a test schedule which includes validation turnaround times for the State.	The testing schedule will be provided as soon as it is available.
188	John Deere	RFP Att. 6.1 (Pro Forma Contract)	2.23.6.5	150	Requirement 2.23.6.5 refers to preventing the "alternation" of finalized records. Should this be "alteration" of finalized records?	Yes. See Section N of this amendment.
189	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.23.6.9	150	Clarification question: The sentence reads: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access. We think you are saying that there will be no internet access to the Contractor's internal systems. But can the Contractor offer Web enabled provider and/or member self service applications – available over the Internet?	Yes to both.
190	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.6.10	151	This requirement states that "the Contractor shall ensure that remote access users of its Systems can only access said Systems via a Virtual Private Network (VPN) and by two-factor user authentication..." It appears that the intent is to provide remote access through a secure protocol using two-factor authentication. Since there are methods other than a VPN that can be used to provide secure access to a Contractor's systems, please consider revising this requirement to read as follows: "the Contractor shall provide remote users of its Systems with a secure method to access said Systems using a two-factor user authentication before allowing access to said network and IS resources accessible therein."	Refer to Sections O and BB of this amendment.
191	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.23.6.10	151	By "two factor authentication" – we assume you mean a security mechanism of "something the user knows and something the user has" – (e.g. an authentication token) – correct?	Two-factor authentication is any authentication protocol that requires two independent ways to establish identity and privileges (as opposed to traditional password authentication, which requires only one factor - knowledge of a password - in order to gain access to a system). Common implementations of two-factor authentication use 'something you know' as one of the two factors, and use either 'something you have' or 'something you are' as the other factor.
192	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.7.3	151	What is your data exchange schedule?	The processes and schedule by which production data will be exchanged between TennCare and the MCOs are explained in the contract. The testing schedule will be provided as soon as it is available.

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193	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.7.5	151	Notice within 60 minutes is very tight, staff alerted by pagers, may take longer than 60 minutes to respond, travel to site, access issue, and then make report. Suggest notify "as soon as practical, not to exceed three (3) hours, of such discovery." Limit reporting to "is negatively impacting" rather than "may jeopardize or is jeopardizing".	The standards in the contract related to these processes will not be revised. Note: "discovery of any problem" implies that a reported or proactively identified potential problem has been confirmed to be a problem.
194	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.7.6	151	Notice within 15 minutes is very tight, may take longer than 15 minutes to respond, access issue, and then make report. Suggest notify "as soon as practical, not to exceed two (2) hours, of such discovery."	The standards in the contract related to these processes will not be revised.
195	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.7.12.1	152	Would the State revise this requirement to allow certain proprietary and confidential materials, such as the BC-DR to be described briefly in the proposal response and supplied for reviewers during a desk audit as part of the readiness review?	The RFP does not require the submission of a BC-DR plan with the MCO's proposal.
196	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.23.9	153	The MCO must, of course, notify TennCare of any significant planned system changes at least 90 days before implementing said change. Does TennCare plan to do the reverse? Example: can TennCare notify the MCO of changes to encounter reporting formats 90 days in advance? This will afford TennCare greater assurances that changes in data interfaces (eligibility, encounter & provider reporting, etc.) can be implemented with greater reliability.	TennCare acknowledges the MCO's interest in receiving adequate notice of TennCare-driven changes in reporting and data exchange requirements. To that end TennCare has established work groups that meet periodically to discuss said matters. All MCOs are expected to participate in these work groups (Refer to Section 2.23.1.4 of the pro forma contract).
197	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.23.9.1	153	Would the State consider changing this requirement to limit “span of control” to the Contractor’s systems only and that notifications are only required when major changes/modifications are being installed (for example, release levels)?	The standards in the contract related to these processes and the associated definitions (e.g., span of control) will not be revised.
198	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.10.2	154	Major systems are purchased and we do not 'own' the manuals. They are copyrighted materials, so we may not be able to distribute, print, etc. them.	This concern is acknowledged; copyrighted materials need to be available to TennCare upon TennCare's request.
199	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.11.2	155	Please clarify what is needed to support TENNCARE personnel, on a secure and read-only basis, to data that can be used in ad hoc reports. Is this a requirement for access to Coventry application systems? Or to supply the state with data extracts?	This is not a requirement for access to transactional systems, but rather for access to online analytics and/or decision support systems and associated querying and reporting tools.
200	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.12.1	155	Please provide clarification on the types of participation activities envisioned for the development of a statewide data warehouse. From the MCO perspective Is this limited to supplying the state with required data extracts, participation in technical workgroups, and data testing/validation? If not, please define the participation required. Also, please supply the timing for initiation of all cross coordination/participation activities and the target implementation date for the data warehouse.	MCO participation in these activities would be primarily for: provision of data extracts, validation and testing of said data, and participation in technical workgroups. The timing and target implementation date for these activities is to be determined.
201	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.23.12.2	155	What is the timeframe that TennCare is looking to implement a Web-accessible community health record for TennCare enrollees?	The State intends to implement the community health record in the fall of 2006.
202	John Deere	RFP Att. 6.1 (Pro Forma Contract)	2.25.5.3	161	Could you please clarify that this requirement refers to the medical, financial, and administrative records relating to services paid by TennCare?	This requirement refers to records relating to services provided pursuant to the Agreement between the MCO and TennCare.
203	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.27.2.13.3	167	We would like to add the words "significant inappropriate" between "any" and "use."	No. Refer to Section P of this amendment.
204	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.27.2.14	167	We would like to add "Upon request" to the beginning of the sentence starting, "Within such thirty (30) days . . . ."	No change.

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205	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.27.2.14	167	This section is inconsistent with section 2.25.6 where it states that the MCO must maintain all files for a period of 5 years after the CRA terminates.	Section 2.27.2.14 is subject to section 2.25.6; therefore, section 2.25.6 applies.
206	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.28.1	169	4.31 should be 4.32.	Agree. Refer to Section Q of this amendment.
207	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.30.4.3	175	Section 2.30.4.3 of the draft contract talks about the provision of supported employment services to SPMI adults. It is our understanding that the current BHO's ceased paying grants related to this service late in 2004. How was this accounted for in the setting of the priority add-on rate?	The grants that were discontinued in 2004 were not specific to supported employment services but rather a type of position (job developer) that was no longer reimbursable by CMS. Thus, the termination of these grants did not impact payments for supported employment services.
208	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.30.4.3	175	This data is not currently captured. Please provide clarification on the level of detail and source of the data.	The MCO shall collect this information from providers. The MCO shall report the percentage by agency and across agencies but shall be able to provide member level data to support the summary data.
209	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.30.4.10	176	Can you please clarify the level of detail and source of the data requested?	This will be provided by TennCare after contract award. TennCare is revising the current TENNderCare report.
210	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.30.6.2	177	Can you please clarify the level of detail and source of the data requested?	The PBM conducts regular reviews of pharmacy data and identifies members for pharmacy lock-in. To the extent that an MCO identifies members for pharmacy lock-in it should identify the member and the basis for referral. Further detail about this will be provided after contract award.
211	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.30.7.1	178	Currently the Provider Enrollment File does not include non-participating providers however, they are in the encounter file. Please provide purpose for including non-participating providers in enrollment file.	Under the current contract, MCOs are required to include non-participating providers in the provider enrollment file.
212	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.30.7.4	178	Can you please clarify the level of detail and source of the data requested?	The format and information required is provided in Attachment IX, Exhibit G. The source of the data is the MCO's network files. This report is required of current contractors.
213	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.30.10.2	179	Please provide clarification on the level of detail and source of the data requested.	Exact format and content requirements for this report will be provided by TennCare after contract award, but the report will include a listing of members who are over the ED threshold as well as information regarding the ED visits made by these members and the MCO case management services provided to these members.
214	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.30.12.3	180	Would telephonic services provided in Spanish by Contractor Member Services Staff who are bilingual need to be reported?	Yes, if the service is provided in response to a "request" for translation/interpretation service.
215	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.30.12.3	180	Would assistance provided by a telephonic translation service utilized by Contractor staff during a member services call need to be reported?	Yes.
216	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.30.18.1	184	This section states that the Type II SAS No.70 examination must be submitted to TennCare only for non-affiliated entities that process claims that represent more than 20% of the MCO's TennCare medical expenses. Please confirm that affiliated entities (e.g. parent or subsidiary organizations) are exempt from the Type II SAS No. 70 examination requirement.	Affiliated entities are exempt from the Type II SAS No. 70 examination requirement.

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217	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.31.2.4.5; 2.31.2.4.8	187	Section 2.31.2.4.5 provides that Sections 2.4.5.1-2.4.5.3, dealing with “Effective Date of Enrollment”, do not apply to State Onlys. However, it also provides that State Onlys can be retroactively eligible “to the date of application.” If State Onlys, by definition, are not eligible for the TennCare Program (see definition in Sec. 1), what does the reference “to date of application” mean? What is the date that defines the CONTRACTOR’S liability for the cost of covered services rendered to State Onlys? Under what circumstances can State Onlys be transferred from another MCO?	The "date of application" referenced in Section 2.31.2.4.5 refers to the date of application to be a State Only or Judicial. This is a different process than the TennCare application process and is operated through TDMHDD. The MCO is responsible for State Onlys or Judicials from when the person's eligibility is effective, which is generally the date of application. State Onlys and Judicials may not change MCOs, but they could be transferred by the State in limited circumstances, e.g., an MCO's contract is terminated.
218	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.31.2.8	188	Please provide clarification on application of Disease Management coverage for Judicials when Judicials are only covered for the services specified by their court order and is expected to be disenrolled after the expiration of the court order.	Some Judicials will be enrolled for services to be rendered on an outpatient basis under Mandatory Outpatient Treatment court orders and others could remain inpatient with medical necessity criteria met for extended periods of time. These individuals are eligible for disease management programs.
219	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	2.31.2.9.8	189	There seems to be a typo in this requirement; Section 2.9.8, Coordination of Dental Benefits, shall not apply to State Onlys and Judicials for **pharmacy** services related to behavioral health diagnoses. Should pharmacy be replaced with **dental**?	There was a typo. Refer to Section R of this amendment.
220	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	2.31.2.17	190	Please confirm that State only's are not to receive any member materials including an ID card.	Correct. State Onlys and Judicials do not receive any member materials, including an ID card. The application for State Only or Judicial coverage is completed by a small number of providers, predominantly CMHAs and RMHIs, who then typically render the necessary behavioral health services. Movement to other providers is unlikely for Judicials, and State Onlys may only change to providers who can complete CRG/TPG assessments. The list of TDMHDD-approved providers is posted on the TDMHDD website along with the manual for the TPG/CRG assessments and the Manual for Mental Health Coverage to Uninsured Tennesseans.
221	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	2.31.2.30	191	Add language: After the word "reports" and before the word "providers" add "that have a behavioral health component".	No change.
222	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.4.4	194	How will renewal rates be calculated? How will the inflation factor be determined, given there will not be credible experience data available to calculated CY2008 capitation rates?	Renewal rates will be determined by applying appropriate inflation factors, as determined by the State's actuary, to the rates effective for the prior rate period.
223	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.4.3.6	194	Will the Bureau provide more information on the John Hopkins ACG Case-Mix System that will be used for risk adjustment?	TennCare will be using the ACG-Medicaid version. Details can be found at www.acg.jhsph.edu.
224	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.4.4	194	The state has proposed that future rates "shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary." We propose that second year rates be developed by an independent actuary selected by agreement of the State and the MCO. Failing this, we propose the state develop a formal arbitration process in the event the state's actuary and the insurer's actuary do not agree on renewal rates.	Future rates will be developed in accordance with the recommendation of the State's actuary.
225	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.4.6	195	Will the Bureau share the actuary's information regarding any adjustments to the capitation rates? The current process could result in the MCO being required to cover additional services not contemplated in its bid.	Yes, the Bureau will share the actuary's recommended adjustment.
226	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	3.7.1.2.1	196	The contractor is required to pay for claims incurred prior to the program start date. Is the expectation that the claims are reimbursed to the providers in accordance with how the state would have paid the claims or how the MCO is contracted with the provider?	The MCO is expected to negotiate reimbursement subject to TennCare prior approval. Refer to Section V and CC of this amendment.

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227	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	3.7.1.2.1	196	Is it expected that the plan's denial process be utilized in the event providers contest amounts received for claims paid by the contractor, for services rendered before the program start date? Or will such issues be handled via an external state fair hearing process?	The MCO's denial process should be available in the event providers contest amounts received for claims paid by the MCO.
228	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.7.1.2.1	196	For the manual payment of services prior to contract start date, how will the contractor know what to reimburse the provider?	Refer to State's Response #226.
229	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.7.1.2.1	196	Will the MCOs that are awarded the contract be required to pay both the medical and behavioral claims run-out from the predecessor?	No.
230	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract) and TennCare Rules & Regulations	3.9 and 1200-13-12-.07	197	This section specifies that the state will withhold established percentages of the MCO's payment each month pending assurances that all quality of care standards and "other requirements" are met. The withhold will not be distributed back to the MCO until compliance with the standards is established. What are the specific standards and other requirements that must be met and how does the state determine or measure compliance?	The specific standards are the responsibilities of the MCO as specified throughout RFP Attachment 6.1. The State monitors compliance on an on going basis. In the event a deficiency is identified, the State will issue a notice of deficiency and request corrective action.
231	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.10.1.2	199	As TennCare is responsible for the enrollment of all members, it seems that the MCO would not be able to fraudulently enroll members, in which case this section is unnecessary.	No change.
232	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	3.11.6	200	If a Contractor had total revenues of $100 and total expenses of $110, what would the risk-sharing amount be under Option 1 and Option 2? If the Contractor had total revenues of $100 and total expenses of $90, what would the risk sharing amount be under Option 1 and Option 2?	**If Revenues = $100, Expenses = $110 and admin expense excluding premium tax equal to seven percent or less:** Under Option 1, the State will pay $5. Under Option 2, the State will pay $2.50. **If Revenues = $100, Expenses = $90 and admin expense excluding premium tax equal to seven percent or less:** Under Option 1, the Contractor will pay the State $7.50. Under Option 2, the Contractor will pay the State $5.
233	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	3.11.7	200	3.11 Indicates submittal to state within 90 days. What is the stated timeframe to review and approve?	The State will review and either approve or request additional information within 90 calendar days of receipt. Refer to Sections W, X and Y of this amendment.
234	Windsor Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.12	202	Amounts paid by the State to a MCO are subject to the 2% HMO tax by virtue of TCA Sec. 56-32-224 and Sec. 3.12 of the pro forma contract. Since it appears that payments by a MCO pursuant to a subcontract with a BHO licensed as a PLHSO are also subject to the 2% HMO tax under TCA Sec. 56-51-152(a) a second time, will the TennCare Bureau increase the minimum and maximum capitation rates for behavioral health services by this additional 2% factor?	In the event an MCO elects to subcontract with an entity that may be subject to the 2% premium tax, TennCare will adjust reimbursement to the MCO. If needed, the pro forma agreement will be amended to reflect the adjustment.
235	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	3.13.3	202	Please describe the state's methodology, process and timeframe for rate changes during the first contract period. Specifically, in year 2 of the contract, what is the process for adjusting the rates? At the bidders conference, reference was made to increases based on some type of index. Will this be based on health plan actual trend data, changes in Tennessee Medicaid program medical expenses or some other approach? When will these changes be announced and will plans have an opportunity to comment on the methodology and results before rate changes are implemented?	Year 1 rates will be effective for the 15 month period from April 1, 2007 through June 30, 2008. However, Year 1 rates may be adjusted to reflect changes in health status risk adjustment scores as specified in RFP Attachment 6.1, Section 3.4.3.2. The payment rates effective July 1, 2008 and annually thereafter will reflect any adjustments for health status and will be further adjusted for inflation as specified in RFP Attachment 6.1, Section 3.4.4. The appropriate inflation index to be used will be determined by the State's actuary. Annual rate changes are generally made available by June 1 or with the passage of the state budget. Refer to Section T of this amendment.
236	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	3.13.3	202	What recourse does the contractor have if they disagree with the adjustment to the rates in following years?	Refer to State's Response #241 and to Section S of this amendment.

#	Proposer Name	Document Reference	Section Number	Page #	Question	Response
237	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	3.13.3	202	Can you please provide clarity on how rates will be established in Year 2?	See RFP Attachment 6.1, Section 3.11.7.
238	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	4.2.2	204	Are the term extensions limited to 2 years (in one year increments) or 5 years (in one year increments).	The term of the Agreement, including any extensions (other than an exigency extension), may not exceed five years. Each extension may be up to one year.
239	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	4.3	205	Section 4.3 include "policies" in the applicable laws section. Policies are not required to be promulgated by the Uniform Administrative Procedures Act but are instead developed totally internally by agencies of the State. As such, this provision allows the TennCare Bureau to unilaterally amend the agreement without the consent of the MCO.	No change. Refer to Section 3.4.5 of the pro forma contract regarding changes that are likely to impact the actuarial soundness of the capitation rates.
240	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	4.3; 4.5.3	205, 211	Our read of this provision is that any orders or consent decrees entered into unilaterally by the State would automatically be incorporated by reference into the agreement and thus binding on the MCO. Is this understanding correct?	Court orders and consent decrees are binding on the MCO. However, as provided in Section 3.4.5 of the pro forma contract, changes that are likely to impact the actuarial soundness of the capitation rate(s) shall be reviewed by TennCare's actuary and the appropriate adjustment to the impacted capitation rate(s) will be made via amendment pursuant to Section 4.21.
241	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	4.4	207	We strongly object to the lack of termination provisions that can be initiated by the MCO. We cannot enter into a legal agreement that could be in force for six years-- involving billions of dollars of health care-- that can only be terminated by the state. The possibility of major changes to the program made by Congress, the legislature or by the courts could make the contract impossible to perform. Since the contract has no limit on financial losses, the MCO must have the ability to terminate the contract with notice. We request that this pro forma contract be amended to include the termination provision of the current MCO contract, which allows for termination with six months notice.	Provision for termination by the Contractor after the initial rate period has been added to the pro forma contract. Refer to Section Z of this amendment.
242	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	4.4.5	208	Is the termination without cause notice period negotiable?	No. Refer to State's Response #243.
243	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	4.4.5	208	Request 90 to 120 days notice for terminations for convenience.	No change to language.
244	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	4.7.2	211	Section 4.7.2 of the pro forma contract indicates that TennCare enrollees are "intended third party beneficiaries" of the agreement, is it the intention of the TennCare Bureau to keep this language in place or is this a provision that the State is open to removing given the liability that this creates for MCOs?	No change. Note that Tennessee courts have held that Medicaid beneficiaries are the intended third party beneficiaries of contracts between the State and providers.
245	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	4.20.2.1.2	216	Please add a verbiage for a "cure period". Current contract states "for deficient deliverables <damages> shall begin on the sixteenth day after notice is provided from TENNCARE to the CONTRACTOR that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days."	There will not be a cure period under this contract.
246	Unison Health Plan	RFP Att. 6.1 (Pro Forma Contract)	4.20.2.2.7	217	We are unable to located CRA section 2.30.14.12, the source of the requirement subject to liquidated damages as specified in item B.15 of the liquidated damages table. Please clarify whether another section should be referenced or whether 2.30.14.12 is missing from the CRA as published.	The reference should be 2.30.14.2. Refer to Section AA of this amendment.
247	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	4.20.2.2.7	219	A.11 - Considering adding "When received directly at the MCO," for clarification.	Since an MCO cannot forward an appeal it hasn't received, no language change is necessary.

#	Proposer Name	Document Reference	Section Number	Page #	Question	Response
248	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	Att. II	239	The copayments appear to be based on poverty level, but the capitation rates paid to the MCOs do not appear to reflect poverty level. Will the member's poverty level indicator be reflected in enrollment files so that the MCOs can properly assess the proper copayment?	The enrollment file includes a poverty level indicator for TennCare Standard enrollees.
249	Centene Corporation	RFP Att. 6.1 (Pro Forma Contract)	Att. III	241	What do you consider an "urban" provider? What size area/city is considered "urban?" More than 50,000 residents?	Urban area is defined by CMS at 42 CFR 412.62(f)(1)(ii) as a MSA defined by OMB.
250	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	Attachment V	247	Please clarify services covered under Illness Management and Recovery and whether this refers to Drop-in Centers.	Illness Management and Recovery refers to an evidence-based practice with an implementation resource kit published by the SAMHSA Center for Mental Health Services. Information, consultation and training on evidence-based practices can be found at www.mentalhealthpractices.org. Illness Management and Recovery is different than drop-in centers, now called peer support centers.
251	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	Attachment V	247	Peer Support Services is something for which the State has only recently drafted guidelines. Clarification of the guidelines for population and frequency is requested.	TDMHDD has not drafted guidelines for peer support services. Peer support services are defined in Attachment I of the pro forma contract. This service is to be rendered as deemed medically necessary.
252	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	Attachment V	247	Please provide clarification on whether Supported Housing will now be a component of Psychiatric Rehab and whether alternatives will be considered.	Supported Housing was, is and will continue to be a component of Psychiatric Rehabilitation services. It is to be provided based on medical necessity. The last clause of this statement regarding alternatives is unclear so State is unable to respond.
253	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	Attachment VII	252	Performance Standards sanctions-The current contract with the MCO's contains sanctions language that imposes liquidated damages when a systemic issue (not meeting goals for the quarter) is found with regard to performance standards. The pro-forma contract contains language that imposes liquidated damages after just one month where a goal was not met. As you are aware, there are times when the State sends out some form of communication to our members, our phone calls spike and it is difficult to meet expectations for the month. Can you clarify the purpose of imposing liquidated damages after one month of missing a goal versus one quarter of missing a goal which may indicate a systemic problem?	Attachment VII of the pro forma contract specifies performance standards, associated liquidated damages for failure to meet the specified standard, and the frequency of measurement for each performance standard (which is either monthly, quarterly or annually depending on the measure). Section 2.24.3 of the pro forma contract states that the "The Contractor agrees TENNCARE may assess liquidated damages for failure to meet the performance standards specified in Attachment VII," which gives the State the option not to impose liquidated damages if it determines they are not warranted based on the particular circumstances.
254	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	Attachment VII	255	Please clarify whether the requirement to provide 76% of SPMI/SED with an annual service excludes Medicare duals.	The requirement to provide 76% of SPMI/SED with an annual service includes Medicare duals.
255	Volunteer State Health Plan	RFP Att. 6.1 (Pro Forma Contract)	Attachment VII	256	#12 - Please provide clarification on how the requirement to reduce patient days at all IMDs by 10% subject to $10,000 liquidated damages annually be shared and/or applied to multiple contractors.	The 10% will apply to each MCO based on patient days in the base year; the $10,000 liquidated damages would apply per MCO.
256	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	Attachment VII	256	#13 - If MCO completes all required EPSDT outreach and education requirements we should not be financially penalized for not reaching 80%.	The performance measure is independent of outreach and education requirements.
257	John Deere Health Plan, Inc.	RFP Att. 6.1 (Pro Forma Contract)	Attachment VII	256	#15 - MCO does not have control over approved drug list or authorization process. MCO can be held to certain provider education but should not be fined for actual generic rate.	The MCO is responsible for managing prescription drug utilization, see Attachment 6.1, Section 2.9.7.
258	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	Attachment IX, Exhibit M	319	Is it necessary to report separate data for the Nurse Triage Line if this service is provided via the Member Services Phone Line?	Yes.
259	AMERIGROUP Corporation	RFP Att. 6.1 (Pro Forma Contract)	Attachment IX, Exhibit M	319	If utilization management services are accessed via the Provider Services Line, should the data in this report be for all calls received via the Provider Services Line or just the subset of calls related to utilization management services?	If utilization management services are accessed via the provider services line, the data in this report should be for the subset of calls related to utilization management services.

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260	CHCcares, Inc.	RFP Att. 6.1 (Pro Forma Contract)	Attachment IX, Exhibit N	321	Attachment IX (MLR Report) requires monthly submission of monthly lag triangle reports. Is this to include just the paid claims data in a triangle format or is the calculation and determination of the IBNR amount required as well?	The calculation and determination of the IBNR amount is required as well (See Attachment IX, Exhibit N.1).
261	Windsor Health Plan	RFP Att. 6.3	A	1	Would the State allow for an Executive Summary with a page limit be submitted with the RFP submission?	Refer to State's Response #30.
262	CHCcares, Inc.	RFP Att. 6.3	A.2	2	Is there a standard format or specific language for the bank reference?	No, but the bank reference must be on bank letterhead.
263	CHCcares, Inc.	RFP Att. 6.3	A.2	2	Is there specific language for the credit references (i.e. we're in good standing; we pay invoices in x days, the length of time that we have been doing business with the vendor)?	No, but the credit reference should include the information referenced in the question.
264	CHCcares, Inc.	RFP Att. 6.3	A.2	2	Can the letter regarding the $500,000 financial commitment come from a parent company instead of a financial institution?	No.
265	Centene Corporation	RFP Att. 6.3	A.2	2	Would the state accept a deposit of $500,000 in the Proposer's account pledged to the State in lieu of the requirement for a general line of credit in this amount?	No.
266	John Deere	RFP Att. 6.3	A.2	2	Please clarify whether the requirement is for a line of credit or a letter of credit. Our interpretation is that a line of credit is required.	Correct. The requirement is for a letter of commitment for a line of credit.
267	Unison Health Plan	RFP Att. 6.3	A.2	2	Is the "valid certificate of insurance indicating liability insurance" referring to a general policy or a managed care E&O policy?	A general policy.
268	Unison Health Plan	RFP Att. 6.3	A.2	2	Does the letter of commitment need to be for a general line of credit or a letter of credit? Under what circumstances would the line/letter of credit be drawn on? Who would have the ability to draw on the line/letter of credit? In lieu of the line/letter of credit, would the Bureau consider having a security deposit for this amount held in custody?	See State's Response #265.
269	CHCcares, Inc.	RFP Att. 6.3	A.3	2	A.3 refers to RFP Section 4.3.9 which is not relevant to the question being asked. Please clarify if this was an accurate reference and if so the administrative intent.	This is an accurate reference. The intent is to ensure that no proposer has a conflict of interest as defined in Section 4.3.9 of the RFP.
270	John Deere	RFP Att. 6.3	A.3	2	Will the State accept a surety bond in place of the line of credit requirement?	No.
271	John Deere	RFP Att. 6.3	A.4	2	Please clarify what form of "evidence" is required to demonstrate that the proposer has applied for a certificate of authority.	Please provide a copy of the cover letter that accompanied your application for a certificate of authority. TennCare will confirm with TDCI that a complete application was submitted.
272	CHCcares, Inc.	RFP Att. 6.3	A.5	3	In reference to "two" recent independently audited financial statements, does the word "two" refer to two years or two reports. The most recent audited statements cover a three year period, is this sufficient? Is this asking for 2 copies of the most recent independently audited financial statement, or one copy of each of the 2 most recent independently audited financial statements?	The request is for one copy of each of the two most recent independently audited financial statements.
273	Unison Health Plan	RFP Att. 6.3	A.5	3	As a current TennCare provider, we are currently not required to obtain or provide a GAAP audit of our financial statements; rather only a Statutory basis financial statement audit is required and prepared. Would the Bureau accept our statutory-basis audited financial statements in satisfaction of this requirement?	The statutory-basis audited financial statements will be accepted.
274	Volunteer State Health Plan	RFP Att. 6.3	A.5	3	For question A.5, the TennCare Bureau currently requires for audited quarterly financial statements to be prepared under statutory principles. Will reports prepared under statutory principles be acceptable to satisfy the requirement under the first bullet?	See State's Response #273.

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275	CHCcares, Inc.	RFP Att. 6.3	B	4	How are the components of this section weighted? Could the State provide weighting for each B item as was provided for the Section C items?	Questions B.1 through B.18 are worth 250 points total. These questions are not individually weighted; rather they will be evaluated together at the discretion of the evaluators.
276	Volunteer State Health Plan	RFP Att. 6.3	B	4	The Bureau of TennCare has provided a very thorough and detailed scoring for Section C of the RFP. However, no detail is provided on how Section B will be scored. Will the Bureau of TennCare provide guidance as to which areas will be weighted more heavily than others in this section? If all areas are rated equally will the Bureau so state?	Refer to State's Response #275.
277	Volunteer State Health Plan	RFP Att. 6.3	B.8	5	B.8 states "Provide a narrative description of the proposed project team, its members, and its organizational structure." Is the State wanting the implementation team for the project, or the actual team that will be performing the work for the contract?	The State wants the actual team that will be performing the work for the contract.
278	John Deere Health Plan, Inc.	RFP Att. 6.3	B.9	5	This section has a page limit of 55 pages. Should resumes of key staff be included in this section, or as an attachment?	Refer to Sections DD, EE, and FF of this amendment.
279	John Deere Health Plan, Inc.	RFP Att. 6.3	B.9	5	Question B. 9 requests resumes of Key Staff. Should the proposer determine who the "Key Staff" are, or should these be the same individuals noted in section 2.29.1 of the model contract?	The key staff are identified in Section 2.29.1 of the pro forma contract.
280	Centene Corporation	RFP Att. 6.3	B.9	5	Please confirm that the resumes and organizational chart will be treated as attachments that will not be counted towards the 55 page limit on the narrative.	This is true. Refer to State's Response #278.
281	Volunteer State Health Plan	RFP Att. 6.3	B.11	6	Question B.11 asks to "provide documentation of Proposer commitment to diversity…" Will Attachments documenting the Proposer's commitment to diversity be accepted?	No, no attachments may be included for question B.11.
282	Centene Corporation	RFP Att. 6.3	B.11	6	2nd bullet, with 3 sub-bullets: Please confirm that the listing of current contracts (including all required information) will be treated as an attachment that will not be counted toward the 55 page limit on the narrative. Counting the listing against the 55 pages puts multi-state plans at a narrative page-length disadvantage relative to regional plans, because multi-state plans have minority and other small business contracts in multiple states, whereas regional contractors have such contracts in only one state. Although the longer listing demonstrates the commitment TennCare is seeking, counting the longer listing against the page limit restricts the pages available to multi-state bidders for narrative on other subsections within Section B.	Refer to State's Response #278.
283	John Deere	RFP Att. 6.3	B.12	6	Could you please clarify the term "contract cost"? Does this refer to total contract dollar amount or value, or something else?	Refer to Section GG of this amendment.
284	Unison Health Plan	RFP Att. 6.3	B.12	6	Please define what the Bureau intended to mean by contract costs. Is it referring to health costs and payments made to providers or is it referring to total costs necessary to operate under the contract including both administration and health cost?	Refer to State's Response #283.
285	Volunteer State Health Plan	RFP Att. 6.3	B.12	6	In question B.12, would you please clarify/define the term "contract costs"?	Refer to State's Response #283.
286	John Deere	RFP Att. 6.3	B.16	7	Please clarify that this question refers only to terminations or non-renewals from a procuring agency of physical or behavioral contracts.	No, this question does not refer only to terminations or non-renewals from a procuring agency of physical or behavioral health contracts; it refers to all terminations or non-renewals.

#	Proposer Name	Document Reference	Section Number	Page #	Question	Response
287	Volunteer State Health Plan	RFP Att. 6.3	C	8-9	The State has indicated one of the most important aspects is integration between physician health and mental health. Please clarify why the State has asked for individual responses for delivering physical health (C.1) and behavioral health (C.2).	The State has asked for individual responses in order to ensure that proposers address physical health as well as behavioral health services. The narrow scope of the questions will allow the State to evaluate the proposer's ability to provide both types of services. Later questions examine the ability of the Contractor to integrate and coordinate these services.
288	CHCcares, Inc.	RFP Att. 6.3	C.27	13	What is the review process to score the questions pertaining to provider network strategy, taking into account existing MCOs will likely have more executed agreements in place, versus new entrants?	The evaluators will score this item based upon the proposer's process for building a network. The number of executed agreements will not be considered in evaluating this item.
289	CHCcares, Inc.	RFP Att. 6.3	C.27	13	What will be the timeframe required for demonstration of executed provider contracts, in consideration of the readiness review?	The Contractor must demonstrate sufficient capacity with executed provider agreements before members will be enrolled in the MCO. This review will occur during the readiness review period.
290	Windsor Health Plan	RFP Att. 6.3	C. 34	14	To clarify, does the State desire a description of the curriculum for initial orientation?	Yes, the State desires a description of the curriculum for initial orientation. The State dos not want the actual curriculum.
291	Volunteer State Health Plan	RFP Att. 6.3	C.52	19	Question C.52 discusses cost avoidance. Do you consider this the same type of cost information that results in the disqualification of the proposal?	The question asks "Describe how you will comply with the requirements for cost avoidance and the collection of third party liability (TPL)…". A description of how you will comply with the requirements does not necessitate the provision of cost figures and they should not be provided. The provision of any cost information will result in disqualification of the proposal.
292	John Deere Health Plan, Inc.	RFP Att. 6.3	C.55	19	Please clarify request in particular if an MCO has not completed 3 different claim management systems, will examples of modifications to existing system fulfill this request?	Question C.55 is not asking for instances where the MCO has deployed three different claims management systems.
293	Volunteer State Health Plan	RFP Att. 6.3	C.58	20	In question C.58, we interpret that the request to provide a copy of the incurred but not paid claims report is not part of the overall page count, is that correct?	This is correct. Refer to Section HH of this amendment.
294	John Deere	RFP Att. 6.3	C.59	20	Does this question refer to IBNR or EBNA?	The acronym "EBNA" is not recognized. The question refers to incurred but not reported (IBNR).
295	Volunteer State Health Plan	RFP Att. 6.3	C.59	20	In Question C.59, we interpret the request to provide a copy of claims payment performance report not to be part of the overall page count, but provided as an attachment. Is that correct?	This is correct. Refer to State's Response #293.
296	John Deere	RFP Att. 6.3	C.60 and C.73	20	A number of the Information Systems requirements require the submission of systems diagrams. Will these diagrams count toward the 23-page limit for this section?	These diagrams do not count toward the page limit. Refer to Section II of this amendment.
297	John Deere	RFP Att. 6.3	C.60 and C.73	20	Please reconsider the page limit for the Information Systems section. The list of requirements is 14 pages in attachment. A limit of 23 pages does not allow us to fully explain how one will or does meet them.	Refer to State's Response #296.
298	Centene Corporation	RFP Att. 6.3	C.60-73	20-24	Please confirm whether diagrams and flowcharts provided in response to Questions C60 - C73 regarding IS will be treated as attachments that will not be counted towards the 23 page limit on the narrative.	Diagrams and flowcharts will be treated as attachments. Refer to State's Response #296.
299	CHCcares, Inc.	RFP Att. 6.3	C.61 d	21	Are these diagrams considered attachments that are not part of the page limit?	Yes. Refer to State's Response #296.
300	Volunteer State Health Plan	RFP Att. 6.3	C.61 d	21	Question C 61, Item A asks for recovery time objectives by major system. Do you want these recovery times listed by function or specific vendor applications?	By system function - refer to the Systems Profile form in the RFP for in-scope systems functions.
301	CHCcares, Inc.	RFP Att. 6.3	C.69	23	Please define typical management information that is accessed or delivered via electronic channels, as discussed in this section.	Refer to Section 2.23.11.2 of the pro forma contract for more information on the related requirement.

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302	CHCcares, Inc.	RFP Att. 6.3	C.71	23	Does the total page limit for the IS section of 23, exclude pages of the required attachment for this question? If not, will consideration be given to exclude this and other required attachments from the section page limit?	Refer to State's Response #296.
303	Volunteer State Health Plan	RFP Att. 6.3	C.71	23	In question C.71, we interpret that Attachment 6.4 is not part of the overall page count, but provided as an attachment. Is that correct?	Yes. Refer to State's Response #296.
304	CHCcares, Inc.	RFP Att. 6.3	C.72	24	Please clarify the format, timeframe and content requested for the System availability and performance report from a current contract/program.	Refer to Section 2.23.16.5 of the pro forma contract for more information on this requirement.
305	Volunteer State Health Plan	RFP Att. 6.3	C.73	24	For C.73, we interpret that Attachment 6.5 is not part of the overall page count, but provided as an attachment. Is that correct?	Yes. Refer to State's Response #296.
306	John Deere	RFP Att. 6.3	C.74	24	Section heading reads “Administration Requirements (Section 2.24 of RFP Attachment 6.1)” but in C.74 section 2.14 is referenced. Do you mean 2.24 in C.74?	Yes. Refer to Section MM of this amendment.
307	Centene Corporation	RFP Att. 6.3	C.74	24	In Question C.74, "2.14" appears to be a typo - is the intended section reference "2.24"? (The previous row references 2.24.)	Yes. Refer to State's Response #306.
308	CHCcares, Inc.	RFP Att. 6.3	C.77	24	Are position titles acceptable for the "individuals" responsible for monitoring?	Yes.
309	Windsor Health Plan	RFP Att. 6.3	C.85	27	Does the actuarial signature in Attachment 6.3 represent an actuarial certification of the reasonableness of the managed care utilization impact assumptions? If yes, does this requested certification fall within the scope of the actuarial scope of expertise and comply with the actuarial standards of practice? Can the actuarial signature requirement for Attachment 6.6 be eliminated?	A qualified actuary should reasonably be able to estimate the managed care savings impact. This does qualify under the scope of actuarial expertise.
310	Volunteer State Health Plan	RFP Att. 6.4	RFP Att. 6.4	2	This document does not appear to in 11 point font or greater. Does this document need to be converted to 11 point font or greater? If so, not all of the columns will fit on 8 1/2 X 11 sheet of paper. Please clarify.	No, this document does not need to be converted to 11 point font.
311	Unison Health Plan	RFP Att. 6.4		2	Please clarify whether affiliated companies using a single system would be considered "multi-client".	"Multi-client" refers to a situation where the same instance of an application being used to perform a system function, e.g. claims processing, is being shared by multiple entities.
312	Windsor Health Plan	RFP Att. 6.6		1	Can the managed care utilization impact assumptions in Attachment 6.6 vary by age-gender-eligibility cohort? May multiple Attachments 6.6 be submitted for different age-gender-eligibility cohorts?	Yes, that would be acceptable.
313	Windsor Health Plan	RFP Att. 6.7		1	Why does the total number of member months in Attachment 6.7 include the State Only & Judicials members but exclude the Priority Add-On members?	The Priority Add-On members are already included in other rate cells since the Priority Add-On rate is paid in addition to the base rate. Since State Only & Judicials only receive behavioral health benefits, they are not already counted in other rate cells. Therefore, the number of member months for State Only & Judicials are shown.
314	Windsor Health Plan	RFP Att. 6.7		1	The exposure for Uninsured / Uninsurable, Age Under 1, is 7 on page 1 Attachment 6.7. In the Data Book, the exposure for this age-gender-eligibility cohort is 83. Which is correct?	Attachment 6.8 shows 83 on page 42 and 104 on the Summary Exhibit on page 77. The 83 is for 12-months, whereas the 104 is for 15-months.
315	Windsor Health Plan	RFP Att. 6.7		1 thru 23	We are using two actuarial firms in developing our response to the cost proposal - one for the medical expense portion excluding mental health and the other for mental health services. As a consequence, we will have two actuaries signing the Cost Scoring and Cost Proposal forms, one for the medical component and the other for the mental health component, Is this acceptable to the State?	Yes.
316	Volunteer State Health Plan	RFP Att. 6.7	RFP Att. 6.7	2 to 23	Will the Bureau accept electronic signatures on these exhibits?	Yes.

#	Proposer Name	Document Reference	Section Number	Page #	Question	Response
317	Windsor Health Plan	RFP Att. 6.7		2,19,20,21,22, &23	Why is the actuary's signature required on the following pages of Attachment 6.7- page 2, page 19, page 20, page 21, page 22 and page 23?	The rates developed should reflect the appropriate level of risk undertaken. The actuary is required to confirm that the rates that were developed are actuarially sound.
318	Centene Corporation	RFP Att. 6.7			Attachment 6.7 references 5,219,931 Member Months for the period April 07 to June 08. This would suggest an average monthly membership of approximately 348,000. What is assumed to be the beginning membership and ending membership during the 15 month time period?	Membership was assumed to be level for the calculation. There were no growth assumptions built into the analysis.
319	United American of Tennessee	RFP Att. 6.8 (Data Book)	B	6	It is stated that final enrollment figures were compared to audited reports produced by the MCO's and BHO's. What were the results of those comparisons?	As specified in RFP Attachment 6.8, page 6, the results varied by less than 1% on enrollment as well.
320	Windsor Health Plan	RFP Att. 6.8 (Data Book)	B	6	Are there specific identifiers such as aid categories that were used to identify the 191,000 members that were disenrolled and the 14,000 members who had their experience reclassified?	Aon received a listing by SSN of all members who were sent disenrollment letters for the 191,000 members referenced in RFP Attachment 6.8, page 6. The disenrollment status was determined by the State, as is all eligibility.
321	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	B	6-10	What types of validations did Aon perform on the State data?	See Attachment 6.8, Section B-Data Sources for details. They were reconciled to invoices submitted by the MCOs & BHOs as well as the MFTs and MLR reports. Under the current TennCare contract, TennCare MCOs/BHOs are required to reconcile the Medical Fund Target (MFT) and Medical Loss Ratio (MLR) reports to the June 30 and Dec 31 NAIC statements (to the income statement detailing the CONTRACTOR's revenues earned and expenses incurred as a result of the CONTRACTOR's participation in the State of Tennessee's TennCare Program). This reconciliation is subsequently verified by TDCI.
322	Unison Health Plan	RFP Att. 6.8 (Data Book)	B & D	6 & 21	On page 6, Aon describes the list of 191,000 members disenrolled as a result of the new reform. Page 21, describes the 137,000 members already disenrolled and the 40,000 that will be disenrolled before the effective date of the contract. Can you reconcile the 191,000 on page 6 with the 177,000 on page 21?	Refer to State's Response #13. 14,000 of the original 191,000 projected for disenrollment were determined eligible for Medicaid.
323	United American of Tennessee	RFP Att. 6.8 (Data Book)	B	7	It is stated that the encounter data for each plan was reconciled to the paid expenditure data reported in the monthly Medical Fund Target Report and varied by less than 1%. Was the encounter data greater or less than the expenditure data?	The fee-for-service encounter data was 0.76% less than the paid expenditure data reported in the Medical Fund Target (MFT) report on a per member per month basis.
324	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	B	7-9	For the behavioral health rate development, can a person be included in more than one report? Are there overlapping members in the reports?	The Priority Add-on cell is the only cell that overlaps with others since it is an additional behavioral health payment for Priority members.
325	Windsor Health Plan	RFP Att. 6.8 (Data Book)	B	8,9	What is the split in estimated care between FFS, CMHCs, RMHIs, TCMCs and grants for SFY 2005?	All the components listed are detailed by line item in the data book except for TCMC, which is approximately 7% of the mental health inpatient line item.
326	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	B	9	What was used as a basis for determining that 80% of behavioral health crisis services expenditures are related to the enrolled population?	Based on a information provided by TDMHDD and the existing BHO, it was determined that 80% was an appropriate amount.
327	Windsor Health Plan	RFP Att. 6.8 (Data Book)	B	9	The data book assumes 80% of payments for crisis services are for TennCare eligibles; will the amount paid to the Contractor be 80% of the amount determined by the State? Where will the other 20% come from to fully fund crisis services teams?	80% of the payment amount is included in the capitation rate development. The State will fund the remaining 20% for non-TennCare enrollees.
328	AMERIGROUP Corporation	RFP Att. 6.8 (Data Book)	C	11	Please provide the number of distinct members in each category for TennCare Medicaid and TennCare Standard.	TennCare Standard is the waiver population and represents all members in the Uninsured/Uninsurable and Waiver Duals categories. Please reference RFP Attachment 6,8, Exhibits 1 through 5 for the number of members.

#	Proposer Name	Document Reference	Section Number	Page #	Question	Response
329	Windsor Health Plan	RFP Att. 6.8 (Data Book)	C	19	How will payments for transportation flow through to a statewide non-emergency transportation contract?	Refer to State's Response #58.
330	Windsor Health Plan	RFP Att. 6.8 (Data Book)	C	20	Are “Claims” in the measurement of Outpatient Hospital (Behavioral Health) actually referring to Services (i.e. not billing cycle related claims)?	As specified in RFP Attachment 6.8, page 20 all behavioral health benefits in the FFS data except for inpatient hospital and professional are on a per claim basis, not services.
331	Windsor Health Plan	RFP Att. 6.8 (Data Book)	C	20	What are the behavioral health expenses incurred for lab and x-ray benefits and what are the utilizatior rates?	Aon does not have lab & x-ray broken out for BHO covered diagnoses only.
332	Windsor Health Plan	RFP Att. 6.8 (Data Book)	C	20	Can the data book be updated to include admissions in addition to days - Exhibits 1 through 17?	The data book is complete and gives an accurate assessment of the population. The admissions rates and average length of stay can be developed by each category from Exhibit 22.
333	Windsor Health Plan	RFP Att. 6.8 (Data Book)	D	21	On page 6 of the Data Book, reference is made to 191,000 disenrolled members. On page 21, the number of disenrolled members is 187,000. What is the difference? Is the difference attributable to children in DCS custody and SSI members?	RFP Attachment 6.8, page 21 references 137,000 currently disenrolled and 40,000 to be disenrolled, leaving a difference of 14,000 members. Page 6 explains that 14,000 members were reclassified as Medicaid members.
334	Windsor Health Plan	RFP Att. 6.8 (Data Book)	D	23	How will the existing vendor (or TennCare) convey to the new MCO/BHO vendor the status of members vis-à-vis the $30,000 lifetime max for substance abuse and max of 10 days of detox? (e.g. will this be flagged in the enrollment file from TennCare?).	A file will be transmitted to the MCO with the information.
335	United American of Tennessee	RFP Att. 6.8 (Data Book)	E	27	The Bureau is anticipating a 2.5% across the board reimbursement increase effective July 1, 2006. What other increases have been granted since 2003?	In addition to built in contract escalators, there have been a few ad hoc increases. There was a 1.5% increase for all practitioners in the Fall of 2005. Also, some providers received an increase for E&M codes at that time (only if their reimbursement was below a certain threshold). This was approximately 0.5% in aggregate. There was an increase in the transportation mileage rate to compensate for increase in fuel costs (Sept 2005 to current). These increases are reflected in the data book.
336	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	E	27	The data book shows an Inpatient RMHI trend of 0%, with an explanation that the TennCare Bureau and the Department of Mental Health and Developmental Disabilities are negotiating a capitation rate designed to have offsetting utilization and cost components. It then says current rate negotiations target an overall reimbursement increase of 4% effective July 1, 2006. Please describe the capitation rate design being negotiated. Can you please confirm there will be no additional rate increases to the RMHI's until after July 1, 2008? Also has the 4% rate increase been agreed to, or have the contract negotiations caused that percentage increase to change?	The contract is still being negotiated and further details cannot be made available at this time. Four percent (4%) is the current overall rate of increase negotiated and is included in the revised data book provided in RFP amendment #3.
337	Windsor Health Plan	RFP Att. 6.8 (Data Book)	E	27	In this section, it is stated that "many of the provider contracts were frozen", Is this statement applicable to the period of SFY 2003 through SFY 2005? Is this statement for hospital and professional providers?	Refer to State's Response #335.
338	Windsor Health Plan	RFP Att. 6.8 (Data Book)	E	27	If the legislature has to approve the projected 2.5% increase in the fee schedule, does this imply that the State has a TennCare fee schedule that can be distributed to the bidders? How does the State fit into the process of setting fees for the TennCare providers?	No, the State does not have a TennCare fee schedule. Provider fees are negotiated between the provider and the MCO.
339	Windsor Health Plan	RFP Att. 6.8 (Data Book)	E	27	How were facility and professional providers being reimbursed during SFY 2005 - methodology and level?	Much of the reimbursements were tied to a percentage of Medicare and paid using similar reimbursement methodologies. A small percentage of claims are paid using a percentage off of billed charges. Overall reimbursement levels can be calculated with data book exhibits.

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340	Windsor Health Plan	RFP Att. 6.8 (Data Book)	E	27	For inpatient hospital services, were hospitals being reimbursed on a per diem, per admission or percent of charges basis during SFY 2005? If multiple reimbursement methodologies were applied, please provide estimated volume under each methodology.	Refer to State's Response #339.
341	Windsor Health Plan	RFP Att. 6.8 (Data Book)	E	27	For outpatient emergency room and surgical services, how were hospitals being reimbursed during SFY 2005 - percent of charges or other methodology to be described?	Refer to State's Response #339.
342	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	E	28-29	An increase of only 1% admin for the transition from an unmanaged FFS program to a tightly managed program in the first year is too aggressive. Other states will allocate 11-13% (in addition to premium tax dollars) in the first year of a managed care program. Please explain your assumption for limiting the increase to only 1%.	Administrative costs are addressed in Attachment 6.8, page 29 of data book. The current administrative level is 6.25%. The State has added 0.75% for some additional managed care initiatives as well as 2% for risk retention, for a total of 9%.
343	United American of Tennessee	RFP Att. 6.8 (Data Book)	E	29	What average length of stay (ALOS) for medical, surgical, and maternity stays are consistent with your definition for a loosely managed program? What are TennCare's ALOS for FY 2005?	The average length of stay can be calculated from Exhibit 22 - Inpatient DRG and is 3.9 days for the members covered by this RFP. The managed care assumptions are built off of days per 1,000.
344	Windsor Health Plan	RFP Att. 6.8 (Data Book)	E	29	What is the behavioral health specific recovery rate for subrogation between non-priority and priority populations? What is the State's TPL experience specifically for behavioral health services?	Only an overall TPL recovery calculation was developed. Specific experience was not determined for the BHO only.
345	Windsor Health Plan	RFP Att. 6.8 (Data Book)	E	29	What is the basis for the assumed "moderately managed" utilization levels assumed in the minimum capitation payment rates?	The utilization levels assumed were built off of Aon's managed care rate manual. See RFP Attachment 6.8, pages 29 and 30 for further discussion.
346	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	F	31	What, if any, costs do they anticipate for an avian flu break-out? Do current trends and claim projections include additional costs for the avian flu? Will the Bureau allocate additional dollars to TennCare if the avian flu were to show up in the middle Tennessee population?	There have been no additional costs integrated into the rates regarding a potential avian flu break-out.
347	Windsor Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 1	32	Why are there very slight base data changes (including member count changes) in the new data book?	See Attachment 6.8, page 6. Additional members who had erroneous location codes or aid categories were assigned to Middle Tennessee. They since had the eligibility data and claims data included.
348	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibits 1 - 8	32-56	The data book shows significant newborn costs under the adult female categories. How are newborn costs handled? Will newborn cap payments be made retroactively to the newborn's date of birth? Should MCOs consider delivery and newborn costs part of the mother's costs or should the newborn cap payment cover ALL newborn costs?	Claims data is tied directly to the eligibility file. When the newborn claim is submitted under the mother's identification, it shows up in the mother's rate cell. This is very typical in the first 30 days.
349	Windsor Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 8	55-56	The Pro Forma Contract Behavioral Health Benefits Chart, 2.6.1.5, includes 24-Hour Psychiatric Residential Treatment as a benefit. Which of the Service Categories for NPMH and PMH include the data associated with historical units and expenditures for 24-Hour Psychiatric Residential Treatment? Can the units, units/1000, paid expenditures/1000 and paid expenditures pmpm be provided separately for analysis?	It is difficult to break out all the components listed. The data book allows enough information in aggregate.

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350	Windsor Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 8	55-56	The Pro Forma Contract Behavioral Health Benefits Chart, 2.6.1.5, indicates in the footnote that licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Which of the Service Categories for NPMH and PMH include the data associated with historical units and expenditures for licensed substance abuse residential treatment facility services? Can the units, units/1000 paid expenditures/1000 and paid expenditures pmpm be provided separately for analysis?	It is difficult to break out all the components listed. The data book allows enough information in aggregate.
351	United American of Tennessee	RFP Att. 6.8 (Data Book)	Exhibit 9	57	When adjusted for exposure, the annual trends from FY 2004 to FY 2005 were 17% for Medicaid (TANF and Related) and 21% for Uninsured/Uninsurable. What were the drivers of this trend? What actions were taken to reduce these trends so that 7 to 8 percent annual trends are appropriate for future periods?	A one-year analysis is not indicative of future trend rates. Please review the trend discussion in RFP Attachment 6.8, pages 27and 28. Aon utilized 3-years of trend to develop the trend assumptions as well as having additional MFT data through Feb. 2006. Proposers should review the expanded MFT report in revised Exhibit 32 (refer to Section OO of this amendment). Fiscal Year 2006 claims are currently running with a negative trend and calendar year 2005 had a 6% trend. There was an anomaly at the end of calendar year 2003 due to reverification that skewed the fiscal year comparisons.
352	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 9	57	What were unit cost and utilization projected trends by category of service for each cap cell and how do these trends compare with those in the base data?	Refer to RFP Attachment 6.8, pages 27 - 28 for a discussion of trend. Trends are available in total for each capitation rate cell on page 57. A 2% unit cost increase was included for professional and outpatient services, with a 4% unit cost increase for behavioral health FFS data.
353	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 9	57	How were the Grier and Newberry decisions considered in the calculation of trend?	Please review the trend discussion on pages 27-28 of the data book. The baseline claims data reflects the program experience when operating under these rulings.
354	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 9	57	What is the justification for the 7% projected trend for Home Health Care in the first contract year? The data book shows a trend of 65% for Disabled and 850% for Duals.	Refer to State's Response #351. In addition, Home health data trends for the state have typically been in line with professional trends. Fiscal Year 2004 appears to be understated, with payments mapped to other categories. Home health coding varied between the years.
355	Windsor Health Plan	RFP Att. 6.8 (Data Book)		57	The FFS annual trend is less than 8.0% overall. The trend calculated from the SFY 2004 and SFY 2005 experience was in the 20% neighborhood for the following aid categories - TANF, Uninsured / Uninsurable, and Disabled. For the Duals eligibility category, the trend was 39%. How is 8.0% overall trend reconciled to actual SFY 2004 and 2005 experience?	Refer to State's Response #351.
356	Unison Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 10	58	The factors related to benefit changes result in either a reduction or no change in cost. Our experience has been that when some services are limited, other non-limited service see increased utilization. Has the Bureau considered this?	The factors developed represent a conservative estimate of the impact of the soft limits. Various impacts, including utilization changes, were considered during the analysis.
357	United American of Tennessee	RFP Att. 6.8 (Data Book)	Exhibit 10	58	Exhibit 22 shows the average length of stay for maternity stays is 2.5 days. This ALOS would be considered well managed for a commercial population. What considerations or data went into the decision to target a 13.6% managed care reduction?	Many factors go into the assumed managed care reductions: admission rates, length of stay, pre-natal care, provider contracting, provider network, etc. The MCO is free to develop their own assumptions as long as they are within the rate ranges. The low end is the maximum reduction we would anticipate an MCO could achieve during the contract period.

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358	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 10	58	Please provide additional information on the development of the managed care assumptions. It appears they were not developed for the specific populations. Does the State and Aon believe it is appropriate to use the same managed care assumptions on populations with drastically difference medical usage?	The managed care assumptions reflect the aggregate difference between a moderately well managed care program and a loosely managed program. It is reasonable to assume that total costs would be impacted in a manner consistent with other large plans. The assumptions are relative calculations, not absolute amounts.
359	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 10; Exhibit 14, Exhibit 15	58, 72, 73	How does the Bureau anticipate managed care savings to be achieved for the dual population? It is unlikely that the same level of managed care savings can be achieved for the dual population as other Medicaid populations, especially when most acute care services are covered by Medicare.	Managed care savings can be achieved for dual members as well. Their distribution of services is significantly different and would reflect reductions appropriately. The reduction in the rates for duals represents less than 6% of the total managed care impact.
360	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 11	59	The data book shows newborn MMs = 78,741; however, VSHP data shows newborn MMs = 158,793. Can the Bureau explain this difference?	Exhibit 32 shows 11,581 newborn admission for those members covered under this RFP. Given that the average exposure for a newborn is close to seven months, the 78,741 member months shown in Exhibit 11 look like a reasonable exposure amount for the data period. Please review the discussion in Attachment 6.8, Page 21 related to excluded members.
361	AMERIGROUP Corporation	RFP Att. 6.8 (Data Book)	Exhibit 18	77	Please identify the Uninsured/Uninsurable Category. Does this refer to the TennCare Standard eligible population or those persons who are eligible for the new Cover TN program? Can you please provide some characteristics of this population? Has this group been covered previously?	The TennCare Standard group is the Uninsured/Uninsurable and Waiver Duals category. Eligibility requirements for TennCare Standard are discussed in RFP Attachment 6.8, page 12.
362	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 18	77	Does the uninsured/uninsurable category include 19 year olds. The RFP is inconsistent in the definition of this group. The previous explanations of those losing TennCare coverage states that Uninsured and Uninsurables age 19 or older would be affected. Yet the RFP includes members in these eligibility classes and age 19 among those whose claims experience is reported.	The uninsured/uninsurable category does not include age nineteen. 574 members turned 19 during the data period. They will be mapped to a Medicaid category in the future but were not flagged in the data period.
363	Centene Corporation	RFP Att. 6.8 (Data Book)	Exhibit 20	83	What is the basis for using 20% in the "% Achieved" column?	Refer to State's Response #364.
364	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 20	87	How was the 20% assumption developed in the analysis of the hard and soft limits?	The Bureau, in conjunction with Aon clinicians, developed the reduction assumption. The 20% assumption was at the low end of the range and is the number developed for the TennCare budget.
365	Windsor Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 20	87	The initial Data Book had a benefit adjustment for Inpatient expense associated with the 20 day limit. Why is this adjustment not in the revised Data Book? Is there any more detail on the impact of the benefit changes that can be shared with the bidders?	Benefit changes are discussed in Attachment 6.8, pages 21 - 24. The same factor for the 20 day limits can be found on page 58. A factor was set to 1.0 under the professional component of the 20 day stay only. This was due to final soft limit changes.
366	Windsor Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 22	127	Are the bed days reported for DRG 391, Normal Newborn, for admissions that extend beyond those of the mothers? For example, if a mother and baby are in the hospital for two days and are discharged at the same time, are there four days of inpatient care recorded - two for the mother for normal vaginal delivery (DRG 371) and two for the baby under (DRF391)? If this is the case, is Aon's assumption of 13.6% reduction in utilization for the maternity and Newborn inpatient hospital categories based on the starting point being overstated?	DRG 391 is the DRG for the complete stay of the newborn. There would be a separate DRG for both the mother and child. Refer to State's Response #356 regarding the managed care savings impact in the minimum rate development. The same DRG logic is consistent with our managed care manual and would therefore not be overstated.
367	Windsor Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 23	130	Does Exhibit 23 represent the actual recalibration baseline that will be used by TennCare when the new MCO/BHO go live on 4/1/07?	Attachment 6.8, Exhibit 23 shows the fiscal year 2005 risk characteristics of the members currently covered under this contract. A more recent but similar calculation will be performed when the MCOs go live that will utilize the most recent enrollment and claims data.

#	Proposer Name	Document Reference	Section Number	Page #	Question	Response
368	Windsor Health Plan	RFP Att. 6.8 (Data Book)	Exhibit 23	130 - 132	What is the SFY 2005 ACG risk factor?	Risk factors were developed based on two complete years of TennCare data. The baseline risk factors were normalized to the risk factor of the overall population, resulting in an aggregate factor of 1.0 for the entire group. When the plan measures risk for each MCO, scores will be determined in relation to the group's aggregate risk score and will be expressed with a score that can be compared to the 1.0 group-wide factor.
369	Centene Corporation	RFP Att. 6.8 (Data Book)		222	It appears that the membership in October 2005 was 412,697. Why is the projected average membership for April 07 to June 08 materially lower than historic membership in the Medical Fund Target Report?	Refer to Section OO of this amendment for revised Attachment 6.8, Exhibit 32. The enrollment has been extended to Feb. 2006, where it was 386,454. Please see Attachment 6.8, page 21 for additional excluded members.
370	Volunteer State Health Plan	RFP Att. 6.8 (Data Book)	Overall		With the removal of 'excluded diagnoses' from the BHO contracts in 2005, new BHO services such as Applied Behavioral Analysis are ramping up in 2006. To what extent does the rate setting take this into account?	Rates are developed that are actuarially determined and represent a best estimate of future expenditures. Many factors have been taken into consideration in the trend development. See RFP Attachment 6.8, pages 27 and 28 and State's Response #351.
371	Centene Corporation	RFP Att. 6.8 (Data Book)			Are the grants a fixed dollar amount? The grants are loaded into the 2007 rates as a PMPM based on projected membership. If that membership changes, there could be more or less of the grant monies to cover the expenses.	Grants are a fixed dollar amount and were developed when aggregate membership was at 1.4 million members. They are no longer tied to membership levels. Higher or lower enrollment would cause the PMPM to deviate proportionally.
372	Centene Corporation	RFP Att. 6.8 (Data Book)			Are the historical paid expenditures net of any copays?	Yes, the historical paid expenditures are the amount paid by the State (which excludes member copay responsibilities).
373	Centene Corporation	RFP Att. 6.8 (Data Book)			Have copays been successfully collected during historical experience period? Do the provided cost models reflect the collection of copays?	See State's Response #372.
374	Centene Corporation	RFP Att. 6.8 (Data Book)			How will capitation rates be adjusted if the State cuts back on prescription drug expenditures relative to what was provided during the historical experience period? Cutting back on prescription drugs can lead to higher costs if other therapies (non-prescription) are required to replace a drug therapy.	The rates will not be adjusted for pharmacy changes. Pharmacy changes during the period in the data book did not result in higher costs for other services.
375	Centene Corporation	RFP Att. 6.8 (Data Book)			What fee schedule is assumed in the cost models?	Rate development is based on the current provider fee arrangements, which vary by service category.
376	Centene Corporation	RFP Att. 6.8 (Data Book)			The cost models in the databook should be provided in Excel so MCO's can perform essential analyses. Is there a reason they are only provided in a pdf? Please provide an Excel workbook with Exhibits 1 through 20 from the Databook.	The State provided electronic copies of data book exhibits in RFP amendment #3. Refer to RFP amendment #3.
377	Windsor Health Plan				When the Middle Tennessee Region MCOs go to risk, will they still be held to the same benefit limit standards that are in the process of being implemented now? The State is thoroughly testing each current MCO to make sure everyone is applying the benefits correctly and in the exact same manner. If so, what will be the testing and implementation process and timeframe for this integration with the other MCOs?	The "hard" non-pharmacy benefit limits originally scheduled to be implemented July 1, 2006 will be implemented as "soft" benefit limits, and the methodology for tracking against the soft benefit limits under this contract will be very similar to what is being tested for July 1. The State will provide this methodology after contract award and testing will occur prior to the start date of operations.
378	CIGNA				Will TennCare consider an option of a no risk contract (at least in year 1)?	No. The State is seeking partners who are willing to take on more risk than under the current program.
379	CIGNA				Will TennCare provide an opportunity for bidders to access current provider contracts?	No. Providers who participate in the TennCare program today in Middle Tennessee are under contract with the current MCOs, TennCare Select and Windsor Health Plan of TN. The MCOs selected in response to this RFP will be required to build their own network.

C. Delete Section 2.6.1.2 in RFP Attachment 6.1 in its entirety and renumber subsequent sections and any cross-references as necessary.

D. Delete row on Pharmacy Services in Section 2.6.1.3 in RFP Attachment 6.1 in its entirety and insert the following in its place:

Pharmacy Services		**Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.** The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see Section 2.6.2.2).

E. Delete row on Non-Emergency Transportation in Section 2.6.1.3 in RFP Attachment 6.1 in its entirety and insert the following in its place

Non-emergency Transportation (including Non-Emergency Ambulance Transportation)		As necessary to get a member to and from covered services, dental services (provided by the DBM), and pharmacy services (provided through the PBM) for enrollees not having access to transportation. If the CONTRACTOR is unable to meet the access standards included in this Agreement (see Section 2.11) for a member, transportation must be provided regardless of whether or not the member has access to transportation. If the member is a child, transportation must be provided in accordance with TENNderCare requirements (see Section 2.7.5.4.6). As with any denial, all notices and actions must be in accordance with the requirements of this Agreement (see Section 2.14.2.2 and Section 2.19). The CONTRACTOR may require advance notice of the need for transportation in order to timely arrange transportation. The CONTRACTOR shall contract with the transportation vendor selected by the State and shall pay the vendor the rate determined by TENNCARE at such time that TENNCARE enters into an agreement with a transportation vendor.

F. Delete Section 2.13.2 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.13.2 **Hospice**

If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least ninety-five percent (95%) of the prevailing Medicaid NF rate to the hospice provider.

G. Delete Section 2.14.1.10.1 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.14.1.10.1 Pre-admission certification process for non-emergency admissions;

H. Delete Section 2.14.1.10.5 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.14.1.10.5 Prospective review of same day surgery procedures.

I. Delete Section 2.14.4.1 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.14.4.1 Emergency and Post-Stabilization Care Services

The CONTRACTOR shall provide emergency services without requiring prior authorization or PCP referral, as described in Section 2.7.1, regardless of whether these services are provided by a contract or non-contract provider. The CONTRACTOR shall provide post-stabilization care services (as defined in Section 1) in accordance with 42 CFR 422.113.

J. Delete Section 2.15.6.3 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.15.6.3 Failure to obtain NCQA accreditation by November 30, 2009 and maintain accreditation thereafter shall be considered a breach of this Agreement and shall result in termination of this Agreement in accordance with the terms set forth in Section 4.4 of this Agreement. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of Final Report from NCQA and may result in termination of this Agreement in accordance with Section 4.4 of this Agreement.

K. Delete Section 2.17.2.3 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.17.2.3 All written materials shall be printed with the assurance of non-discrimination as provided in Section 4.32.1;

L. Delete Section 2.19.2.18 in RFP Attachment 6.1 in its entirety and renumber subsequent sections as necessary.

M. Delete Section 2.23.2.4.3 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.23.2.4.3 The CONTRACTOR shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.

N. Delete Section 2.23.6.5 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.23.6.5 The CONTRACTOR's Systems shall have inherent functionality that prevents the alteration of finalized records.

O. Delete Section 2.23.6.10 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.23.6.10 The CONTRACTOR shall ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by TENNCARE.

P. Delete Section 2.27.2.13.3 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.27.2.13.3 Agree to report to TENNCARE any unauthorized use or disclosure, not otherwise permitted or required by HIPAA, of TENNCARE enrollee PHI or of any security incident of which CONTRACTOR becomes aware.

Q. Delete Section 2.28.1 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.28.1 The CONTRACTOR shall comply with Section 4.32 of this Agreement regarding non-discrimination, proof of non-discrimination, and notices of non-discrimination.

R. Delete Section 2.31.2.9.8 in RFP Attachment 6.1 in its entirety and insert the following in its place:

2.31.2.9.8 Section 2.9.8, Coordination of Dental Benefits, shall not apply to State Onlys and Judicials.

S. Delete Section 3.4.3.5 in RFP Attachment 6.1 in its entirety and insert the following in its place:

3.4.3.5 In addition to the annual recalibration of risk adjustment factors, those factors will be updated when there is a significant change in program participation. This may occur when an MCO enters or leaves a Grand Region. If an MCO withdraws from a Grand Region, that MCO's membership may be temporarily distributed to TennCare Select or distributed to the remaining MCOs or to new MCOs. New risk adjustment values for the remaining MCOs or new MCO(s) will be calculated that consider the population that will be enrolled in the MCO for the remainder of the contract year only. In this instance, MCOs would be given the option to provide TENNCARE, in writing, with a six (6) months notice of termination in accordance with Section 4.4.6.2. This notice option is not available for rate adjustments as described in Sections 3.4.3.1 through 3.4.3.4.

T. Delete Section 3.4.4 in RFP Attachment 6.1 in its entirety and insert the following in its place:

3.4.4 Beginning with capitation payment rates effective July 1, 2008, in addition to other adjustments specified in Section 3.4 of this Agreement, the base capitation rates originally proposed by the CONTRACTOR as subsequently adjusted and the priority add-on rates and State Only and Judicials rates originally specified by the State shall be adjusted annually for inflation in accordance with the recommendation of the State's actuary.

U. Add the following Section 3.4.7 to Attachment 6.1 and renumber any subsequent sections as necessary:

3.4.7 In the event TENNCARE requires that the CONTRACTOR contract with the transportation vendor selected by the State, TENNCARE shall have its independent actuary determine whether the change would impact the actuarial soundness of the capitation rate(s). If TENNCARE's independent actuary determines that the change would impact the actuarial soundness of one or more of the capitation rates, the actuary shall determine the appropriate adjustment to the impacted capitation rate(s).

V. Delete Section 3.7.1.2.1 in RFP Attachment 6.1 in its entirety and insert the following in its place:

3.7.1.2.1 The CONTRACTOR agrees to manually process claims and reimburse providers for services incurred prior to the start date of operations of this Agreement; however, the CONTRACTOR will not be at risk for these services. The CONTRACTOR shall be paid two dollars ($2.00) per claim as reimbursement for processing claims for services incurred prior to the start date of operations. Actual expenditures for covered services and the allowed amount for claims processing are subject to TCA 56-32-224. The CONTRACTOR shall negotiate provider reimbursement subject to TENNCARE prior approval and prepare checks for payment of providers for the provision of covered services incurred during an enrollee's period of eligibility prior to the start date of operations on an as needed basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable

form and format at least forty-eight (48) hours in advance of distribution of any provider payment related to this requirement. TENNCARE shall remit payment to the CONTRACTOR in an amount equal to: the amount to be paid to providers; plus, two dollars ($2.00) per claim processed by the CONTRACTOR; plus, an amount sufficient to cover any payment due in accordance with TCA 56-32-224 within forty-eight (48) hours of receipt of notice. The CONTRACTOR shall then release payments to providers within twenty-four (24) hours of the receipt of funds from the State. The CONTRACTOR is responsible for any payments required pursuant to TCA 56-32-224.

W. Delete Section 3.11.5.2 in RFP Attachment 6.1 in its entirety and insert the following in its place:

3.11.5.2 Reconciled and submitted to the State within ninety (90) calendar days of the end of the settlement period. The settlement periods shall be as follows:

3.11.5.2.1 April 1, 2007 through June 30, 2008;

3.11.5.2.2 July 1, 2008 through June 30, 2009;

3.11.5.2.3 July 1, 2009 through June 30, 2010;

3.11.5.2.4 July 1, 2010 through June 30, 2011; and

3.11.5.2.5 July 1, 2011 through the Agreement end date.

X. Delete Section 3.11.7.1 in RFP Attachment 6.1 in its entirety and insert the following in its place:

3.11.7.1 The CONTRACTOR shall submit a preliminary risk-sharing settlement calculation within ninety (90) calendar days of the end of the settlement period specified in Section 3.11.5.2.

Y. Delete Section 3.11.7.4 in RFP Attachment 6.1 in its entirety and insert the following in its place:

3.11.7.4 Upon approval of the CONTRACTOR's preliminary risk-sharing calculation, TENNCARE or the CONTRACTOR, depending on whether the CONTRACTOR has incurred a profit or loss, will make monthly payments to the other party based on actual profits or losses for the settlement period as reported on the CONTRACTOR's MLR report. For the purpose of this requirement, actual profits or losses shall not include incurred but not reported expenses. Risk-sharing settlements if applicable shall be made on a cash basis as documented on the CONTRACTOR's MLR report (see Section 2.30.14.2.1). TENNCARE shall either approve the CONTRACTOR's preliminary risk-sharing calculation or request additional documentation within ninety (90) calendar days of receipt. In the event TENNCARE is sharing in a loss, TENNCARE shall remit payment for its share of the loss within thirty (30) calendar days of receipt of the CONTRACTOR's MLR report and any administrative cost information requested by TENNCARE. In the event of a gain, the CONTRACTOR shall remit payment for TENNCARE's share of the gain with submission of the CONTRACTOR's MLR report.

Z. Add the following new Section 4.4.6 in RFP Attachment 6.1 and renumber subsequent sections and any cross-references as necessary:

4.4.6 **Termination by CONTRACTOR**

4.4.6.1 Beginning in calendar year 2008, the CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination on or by July 1 of each calendar year after receipt of notice of the capitation payment rates to become effective in July. Said notice shall terminate the Agreement on the following December 31st.

4.4.6.2 The CONTRACTOR shall have the option to provide TENNCARE with a six (6) months notice of termination when risk adjustment factors are updated in accordance with Section 3.4.3.5 due to a significant change in program participation. In this instance, the CONTRACTOR shall provide TENNCARE with written notice of termination within fourteen

(14) calendar days of notice of the updated risk adjustment factors and capitation payment rates. Said notice shall terminate the Agreement six (6) months after the date of notice of risk adjustment factors and capitation payment rates plus fourteen (14) calendar days.

AA. Delete item B.15 in Section 4.20.2.2.7 in RFP Attachment 6.1 in its entirety and insert the following in its place:

B.15	Failure to require and ensure compliance with Ownership and Disclosure requirements as required in Section 2.21.8 and 2.30.14.2 of this Agreement		$5000 per provider application for each application that is signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B

BB. Add the following new item 68 to Attachment VII to Attachment 6.1 and renumber any subsequent items as necessary:

68. Proposed approach for remote access in accordance with Section 2.23.6.10.

CC. Add the following new item 156 to Attachment VII to Attachment 6.1 and renumber any subsequent items as necessary:

156. Provider reimbursement rates for services incurred prior to the start date of operations in accordance with Section 3.7.1.2.1.

DD. Delete the third sentence in RFP Attachment 6.3, Section B and insert the following in its place:

The Proposal Evaluation Teams may elect to not evaluate any part of the Qualifications and Experience response that exceeds the 75 page maximum without attachments.

EE. Delete the header in the second column of RFP Attachment 6.3, Section B and insert the following in its place:

Qualifications & Experience Items (75 page maximum for items B.1 through B.8 and B.10 through B.18; item B.9 is an attachment and does not count toward the page limit)

FF. Delete item B.9 in RFP Attachment 6.3, Section B and insert the following in its place:

B.9 Attach a personnel roster and resumes of key people who shall be assigned by the Proposer to perform duties or services under the contract as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority.

GG. Delete item B.12 in RFP Attachment 6.3, Section B and insert the following in its place:

B.12 Identify all other publicly-funded managed care contracts for Medicaid/SCHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, please provide a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types, the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any.

HH. Delete header between item C.52 and item C.53 in RFP Attachment 6.3, Section C and insert the following in its place:

Claims Management (Section 2.22 of RFP Attachment 6.1) (Responses to items C.53 through C.57 shall not exceed 6 pages.)

II. Delete header between item C.59 and item C.60 in RFP Attachment 6.3, Section C and insert the following in its place:

Information Systems (Section 2.23 of RFP Attachment 6.1) (Responses to items C.60 through C.70 shall not exceed 30 pages.)

JJ. Delete item C.71 in RFP Attachment 6.3, Section C and insert the following in its place:

C.71 Using the instructions and format in RFP Attachment 6.4, attach a detailed profile of the key information systems within your span of control.

KK. Delete item C.72 in RFP Attachment 6.3, Section C and insert the following in its place:

C.72 Attach a sample System availability and performance report from a current contract/program.

LL. Delete item C.73 in RFP Attachment 6.3, Section C and insert the following in its place:

C.73 Following the instructions and format in RFP Attachment 6.5 attach a profile of your Information Systems (IS) organization.

MM. Delete item C.74 in RFP Attachment 6.3, Section C and insert the following in its place:

C.74 Please describe how you will ensure compliance with the requirements in Attachment 6.1, Section 2.24. As part of your response, provide your proposed approach to the development of a contract compliance plan.

NN. Delete Exhibit 23 in RFP Attachment 6.8 in its entirety and insert the attached, revised Exhibit 23 in its place.

OO. Delete Exhibit 32 in RFP Attachment 6.8 in its entirety and insert the attached, revised Exhibit 32 in its place.

PP. For informational purposes, refer to Attachment A of this RFP Amendment #4.

QQ. For informational purposes, refer to Attachment B of this RFP Amendment #4.

TennCare **Exhibit 23**

Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment
Medicaid (TANF & Related)

ACG Code	Description	Exposure	Claims	Billed	Paid
0000	No Claim Submitted	484,642	-	$ -	$ -
0100	Acute Minor, Age 1	12,588	6,146	$ 989,933	$ 392,809
0200	Acute Minor, Age 2 to 5	58,853	18,003	$ 2,952,104	$ 1,098,848
0300	Acute Minor, Age > 5	113,391	29,787	$ 5,675,743	$ 1,869,515
0400	Acute Major	32,726	10,957	$ 5,283,100	$ 1,378,372
0500	Likely to Recur, w/o Allergies	44,358	11,219	$ 2,507,670	$ 859,091
0600	Likely to Recur, with Allergies	9,595	2,560	$ 441,714	$ 165,945
0700	Asthma	2,481	558	$ 96,624	$ 38,241
0800	Chronic Medical, Unstable	1,989	988	$ 603,715	$ 206,205
0900	Chronic Medical, Stable	9,424	2,631	$ 520,021	$ 181,249
1000	Chronic Specialty	379	143	$ 34,752	$ 12,905
1100	Eye/Dental	40,747	7,709	$ 1,561,582	$ 741,426
1200	Chronic Specialty, Unstable	677	165	$ 44,718	$ 16,441
1300	Psychosocial, w/o Psych Unstable	8,005	2,383	$ 404,134	$ 153,021
1400	Psychosocial, with Psych Unstable, w/o Psych Stable	432	114	$ 103,117	$ 78,251
1500	Psychosocial, with Psych Unstable, w/ Psych Stable	276	80	$ 26,654	$ 4,265
1600	Preventive/Administrative	82,776	14,664	$ 2,007,905	$ 1,082,281
1710	Pregnancy: 0-1 ADGs	8,582	10,361	$ 7,721,696	$ 2,802,721
1720	Pregnancy: 2-3 ADGs, no Major ADGs	22,734	31,120	$ 20,169,790	$ 6,994,309
1730	Pregnancy: 2-3 ADGs, 1+ Major ADGs	4,032	5,681	$ 5,768,345	$ 2,133,835
1740	Pregnancy: 4-5 ADGs, no Major ADGs	25,345	40,690	$ 24,671,247	$ 8,237,835
1750	Pregnancy: 4-5 ADGs, 1+ Major ADGs	12,172	19,743	$ 15,766,448	$ 5,420,010
1760	Pregnancy: 6+ ADGs, no Major ADGs	38,068	82,640	$ 45,251,958	$ 14,191,750
1770	Pregnancy: 6+ ADGs, 1+ Major ADGs	98,468	274,317	$ 213,247,324	$ 68,997,981
1800	Acute Minor and Acute Major	106,364	58,992	$ 25,520,992	$ 7,008,967
1900	Acute Minor and Likely to Recur, Age 1	32,319	26,116	$ 4,540,579	$ 1,688,974
2000	Acute Minor and Likely to Recur, Age 2 to 5	86,601	44,668	$ 7,484,222	$ 2,755,779
2100	Acute Minor and Likely to Recur, Age > 5, w/o Allergy	72,591	29,797	$ 5,862,190	$ 1,949,086
2200	Acute Minor and Likely to Recur, Age > 5, with Allergy	27,759	12,680	$ 2,128,975	$ 806,024
2300	Acute Minor and Chronic Medical: Stable	14,453	6,119	$ 1,258,552	$ 417,495
2400	Acute Minor and Eye/Dental	34,035	13,395	$ 2,559,835	$ 993,977
2500	Acute Minor and Psychosocial, w/o Psych Unstable	13,391	6,003	$ 1,224,786	$ 389,744
2600	Acute Minor and Psychosocial, with Psych Unstable, w/o Psych Stable	475	156	$ 31,000	$ 8,607
2700	Acute Minor and Psychosocial, with Psych Unstable and Psych Stable	268	141	$ 36,765	$ 8,937

TennCare **Exhibit 23**

Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment

2800	Acute Minor and Likely to Recur	20,721	9,584	$	4,089,556	$	1,159,792
2900	Acute Minor/Acute Major/Likely to Recur, Age 1	25,612	32,143	$	8,255,979	$	2,624,637
3000	Acute Minor/Acute Major/Likely to Recur, Age 2 to 5	57,508	48,825	$	12,714,673	$	3,867,188
3100	Acute Minor/Acute Major/Likely to Recur, Age 6 to 11	37,888	28,136	$	8,407,598	$	2,367,104
3200	Acute Minor/Acute Major/Likely to Recur, Age > 11, w/o Allergy	53,687	46,845	$	20,405,232	$	5,348,318
3300	Acute Minor/Acute Major/Likely to Recur, Age > 11, with Allergy	14,783	13,538	$	4,222,657	$	1,160,142
3400	Acute Minor/Likely to Recur/Eye & Dental	40,814	25,315	$	5,244,517	$	1,834,667
3500	Acute Minor/Likely to Recur/Psychosocial	19,257	12,923	$	2,592,192	$	899,211
3600	Acute Minor/Acute Major/Likely Recur/Eye & Dental	66,797	84,637	$	39,023,860	$	9,954,291
3700	Acute Minor/Acute Major/Likely Recur/Psychosocial	42,214	49,930	$	19,253,535	$	5,268,131
3800	2-3 Other ADG Combinations, Age < 18	90,295	36,646	$	10,153,532	$	3,268,466
3900	2-3 Other ADG Combinations, Males Age 18 to 34	7,722	3,495	$	2,054,419	$	540,158
4000	2-3 Other ADG Combinations, Females Age 18 to 34	19,273	9,694	$	3,511,606	$	1,031,485
4100	2-3 Other ADG Combinations, Age > 34	22,015	12,270	$	5,608,284	$	1,631,613
4210	4-5 Other ADG Combinations, Age < 18, no Major ADGs	96,452	66,749	$	16,087,166	$	5,234,659
4220	4-5 Other ADG Combinations, Age < 18, 1+ Major ADGs	31,174	21,943	$	8,623,865	$	2,436,895
4310	4-5 Other ADG Combinations, Age 18 to 44, no Major ADGs	31,886	24,056	$	7,864,892	$	2,165,951
4320	4-5 Other ADG Combinations, Age 18 to 44, 1+ Major ADGs	20,918	17,818	$	8,832,249	$	2,398,959
4330	4-5 Other ADG Combinations, Age 18 to 44, 2+ Major ADGs	5,298	5,093	$	4,747,177	$	1,313,588
4410	4-5 Other ADG Combinations, Age > 44, no Major ADGs	4,416	3,605	$	1,091,017	$	328,355
4420	4-5 Other ADG Combinations, Age > 44, 1+ Major ADGs	6,326	6,942	$	4,320,239	$	1,353,591
4430	4-5 Other ADG Combinations, Age > 44, 2+ Major ADGs	2,499	3,281	$	3,693,068	$	1,064,458
4510	6-9 Other ADG Combinations, Age < 6, no Major ADGs	39,749	49,022	$	13,020,431	$	4,078,356
4520	6-9 Other ADG Combinations, Age < 6, 1+ Major ADGs	29,870	38,710	$	14,922,796	$	4,214,617
4610	6-9 Other ADG Combinations, Age 6 to 17, no Major ADGs	66,817	77,090	$	21,107,672	$	6,350,171
4620	6-9 Other ADG Combinations, Age 6 to 17, 1+ Major ADGs	34,650	39,617	$	19,596,993	$	5,685,220
4710	6-9 Other ADG Combinations, Males, Age 18 to 34, no Major ADGs	3,635	4,074	$	1,555,244	$	404,253
4720	6-9 Other ADG Combinations, Males, Age 18 to 34, 1+ Major ADGs	6,434	8,845	$	4,668,422	$	1,213,662
4730	6-9 Other ADG Combinations, Males, Age 18 to 34, 2+ Major ADGs	5,687	10,192	$	10,108,202	$	3,478,337
4810	6-9 Other ADG Combinations, Females, Age 18 to 34, no Major ADGs	26,201	35,412	$	12,391,087	$	3,312,395
4820	6-9 Other ADG Combinations, Females, Age 18 to 34, 1+ Major ADGs	26,264	37,744	$	17,146,564	$	4,637,371
4830	6-9 Other ADG Combinations, Females, Age 18 to 34, 2+ Major ADGs	12,690	19,430	$	13,108,590	$	3,694,213
4910	6-9 Other ADG Combinations, Age > 34, 0-1 Major ADGs	43,378	65,152	$	30,319,151	$	8,425,747
4920	6-9 Other ADG Combinations, Age > 34, 2 Major ADGs	20,366	38,104	$	26,951,033	$	7,594,272
4930	6-9 Other ADG Combinations, Age > 34, 3 Major ADGs	6,060	13,901	$	14,915,343	$	4,361,721
4940	6-9 Other ADG Combinations, Age > 34, 4+ Major ADGs	979	3,272	$	5,450,899	$	1,509,696
5010	10+ Other ADG Combinations, Age 1 to 17, no Major ADGs	14,727	29,623	$	8,900,840	$	2,647,648

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Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

		John Hopkins' ACG Risk Assessment				
5020	10+ Other ADG Combinations, Age 1 to 17, 1 Major ADGs	19,163	37,775	$ 14,403,700	$	4,199,205
5030	10+ Other ADG Combinations, Age 1 to 17, 2 Major ADGs	16,051	34,801	$ 29,980,074	$	8,391,627
5040	10+ Other ADG Combinations, Age > 17, 0-1 Major ADGs	40,468	103,133	$ 47,910,892	$	12,548,147
5050	10+ Other ADG Combinations, Age > 17, 2 Major ADGs	43,718	131,661	$ 75,781,182	$	20,836,811
5060	10+ Other ADG Combinations, Age > 17, 3 Major ADGs	32,991	120,684	$ 82,829,182	$	22,750,679
5070	10+ Other ADG Combinations, Age > 17, 4+ Major ADGs	27,887	149,157	$ 158,236,697	$	46,373,402
5100	No Diagnosis or Only Unclassified Diagnosis & Non-Users (1 input file)	1,728	3,752	$ 2,430,578	$	501,104
5310	Infants: 0-5 ADGs, no Major ADGs	67,359	69,784	$ 15,379,131	$	5,678,885
5320	Infants: 0-5 ADGs, 1+ Major ADGs	5,665	7,652	$ 7,901,788	$	3,296,187
5330	Infants: 6+ ADGs, no Major ADGs	23,523	47,238	$ 13,012,907	$	4,414,979
5340	Infants: 6+ ADGs, 1+ Major ADGs	19,843	51,677	$ 44,778,029	$	16,970,221
9900	Invalid Age or Date of Birth	13,030	27,000	$ 31,238,225	$	12,857,668
Total		2,867,484	2,588,694	$ 1,345,341,155	$	410,763,151

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Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment
Uninsured/Uninsurable

ACG Code	Description	Exposure	Claims	Billed	Paid
0000	No Claim Submitted	31,414	-	$ -	$ -
0100	Acute Minor, Age 1	347	170	$ 21,514	$ 9,906
0200	Acute Minor, Age 2 to 5	2,553	868	$ 118,553	$ 49,097
0300	Acute Minor, Age > 5	9,903	2,638	$ 380,967	$ 139,700
0400	Acute Major	2,086	647	$ 270,458	$ 65,187
0500	Likely to Recur, w/o Allergies	2,991	798	$ 174,314	$ 57,797
0600	Likely to Recur, with Allergies	665	264	$ 25,277	$ 12,011
0700	Asthma	147	30	$ 3,769	$ 1,715
0800	Chronic Medical, Unstable	190	84	$ 27,384	$ 10,563
0900	Chronic Medical, Stable	500	123	$ 18,599	$ 8,139
1000	Chronic Specialty	51	10	$ 1,029	$ 532
1100	Eye/Dental	4,700	865	$ 140,056	$ 84,230
1200	Chronic Specialty, Unstable	55	7	$ 1,185	$ 686
1300	Psychosocial, w/o Psych Unstable	629	264	$ 32,074	$ 12,154
1400	Psychosocial, with Psych Unstable, w/o Psych Stable	18	8	$ 968	$ 422
1500	Psychosocial, with Psych Unstable, w/ Psych Stable	4	1	$ 288	$ -
1600	Preventive/Administrative	6,375	1,086	$ 134,442	$ 79,476
1710	Pregnancy: 0-1 ADGs	35	31	$ 3,437	$ 1,460
1720	Pregnancy: 2-3 ADGs, no Major ADGs	238	216	$ 121,669	$ 31,254
1730	Pregnancy: 2-3 ADGs, 1+ Major ADGs	5	9	$ 3,919	$ 726
1740	Pregnancy: 4-5 ADGs, no Major ADGs	210	258	$ 146,540	$ 42,023
1750	Pregnancy: 4-5 ADGs, 1+ Major ADGs	121	152	$ 84,954	$ 34,868
1760	Pregnancy: 6+ ADGs, no Major ADGs	547	943	$ 317,802	$ 96,099
1770	Pregnancy: 6+ ADGs, 1+ Major ADGs	984	1,921	$ 1,303,958	$ 334,168
1800	Acute Minor and Acute Major	6,045	3,666	$ 1,431,594	$ 342,553
1900	Acute Minor and Likely to Recur, Age 1	961	822	$ 142,887	$ 56,077
2000	Acute Minor and Likely to Recur, Age 2 to 5	4,151	2,164	$ 318,822	$ 116,971
2100	Acute Minor and Likely to Recur, Age > 5, w/o Allergy	6,692	2,779	$ 540,122	$ 173,060
2200	Acute Minor and Likely to Recur, Age > 5, with Allergy	3,318	1,728	$ 236,960	$ 97,832
2300	Acute Minor and Chronic Medical: Stable	898	364	$ 67,553	$ 28,815
2400	Acute Minor and Eye/Dental	3,772	1,403	$ 231,653	$ 100,966
2500	Acute Minor and Psychosocial, w/o Psych Unstable	767	324	$ 54,627	$ 18,778
2600	Acute Minor and Psychosocial, with Psych Unstable, w/o Psych Stable	40	13	$ 3,023	$ 756
2700	Acute Minor and Psychosocial, with Psych Unstable and Psych Stable	0	-	$ -	$ -

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Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment

2800	Acute Minor and Likely to Recur	1,028	516	$	190,148	$	46,271
2900	Acute Minor/Acute Major/Likely to Recur, Age 1	521	652	$	145,564	$	42,679
3000	Acute Minor/Acute Major/Likely to Recur, Age 2 to 5	2,715	2,453	$	581,362	$	171,840
3100	Acute Minor/Acute Major/Likely to Recur, Age 6 to 11	3,850	3,138	$	903,237	$	257,160
3200	Acute Minor/Acute Major/Likely to Recur, Age > 11, w/o Allergy	3,083	2,538	$	877,757	$	224,255
3300	Acute Minor/Acute Major/Likely to Recur, Age > 11, with Allergy	1,214	1,161	$	275,227	$	78,293
3400	Acute Minor/Likely to Recur/Eye & Dental	4,294	2,695	$	396,502	$	182,308
3500	Acute Minor/Likely to Recur/Psychosocial	1,039	687	$	113,213	$	43,299
3600	Acute Minor/Acute Major/Likely Recur/Eye & Dental	2,539	2,886	$	965,603	$	252,025
3700	Acute Minor/Acute Major/Likely Recur/Psychosocial	1,929	2,160	$	785,093	$	192,281
3800	2-3 Other ADG Combinations, Age < 18	9,072	4,227	$	1,194,578	$	370,571
3900	2-3 Other ADG Combinations, Males Age 18 to 34	371	197	$	72,085	$	14,644
4000	2-3 Other ADG Combinations, Females Age 18 to 34	397	235	$	60,735	$	19,156
4100	2-3 Other ADG Combinations, Age > 34	0	-	$	-	$	-
4210	4-5 Other ADG Combinations, Age < 18, no Major ADGs	9,529	6,933	$	1,676,515	$	527,321
4220	4-5 Other ADG Combinations, Age < 18, 1+ Major ADGs	2,985	2,386	$	988,275	$	241,633
4310	4-5 Other ADG Combinations, Age 18 to 44, no Major ADGs	370	280	$	85,720	$	26,656
4320	4-5 Other ADG Combinations, Age 18 to 44, 1+ Major ADGs	300	228	$	85,858	$	25,434
4330	4-5 Other ADG Combinations, Age 18 to 44, 2+ Major ADGs	98	101	$	35,131	$	8,251
4410	4-5 Other ADG Combinations, Age > 44, no Major ADGs	0	-	$	-	$	-
4420	4-5 Other ADG Combinations, Age > 44, 1+ Major ADGs	0	-	$	-	$	-
4430	4-5 Other ADG Combinations, Age > 44, 2+ Major ADGs	0	-	$	-	$	-
4510	6-9 Other ADG Combinations, Age < 6, no Major ADGs	1,314	1,598	$	366,221	$	119,302
4520	6-9 Other ADG Combinations, Age < 6, 1+ Major ADGs	1,181	1,805	$	698,917	$	191,583
4610	6-9 Other ADG Combinations, Age 6 to 17, no Major ADGs	7,628	9,404	$	2,579,791	$	759,547
4620	6-9 Other ADG Combinations, Age 6 to 17, 1+ Major ADGs	4,571	5,992	$	3,094,757	$	985,914
4710	6-9 Other ADG Combinations, Males, Age 18 to 34, no Major ADGs	42	61	$	22,636	$	7,000
4720	6-9 Other ADG Combinations, Males, Age 18 to 34, 1+ Major ADGs	102	117	$	55,853	$	14,036
4730	6-9 Other ADG Combinations, Males, Age 18 to 34, 2+ Major ADGs	149	297	$	312,829	$	69,199
4810	6-9 Other ADG Combinations, Females, Age 18 to 34, no Major ADGs	427	597	$	215,430	$	63,466
4820	6-9 Other ADG Combinations, Females, Age 18 to 34, 1+ Major ADGs	189	277	$	86,182	$	23,818
4830	6-9 Other ADG Combinations, Females, Age 18 to 34, 2+ Major ADGs	126	177	$	66,610	$	22,120
4910	6-9 Other ADG Combinations, Age > 34, 0-1 Major ADGs	0	-	$	-	$	-
4920	6-9 Other ADG Combinations, Age > 34, 2 Major ADGs	0	-	$	-	$	-
4930	6-9 Other ADG Combinations, Age > 34, 3 Major ADGs	0	-	$	-	$	-
4940	6-9 Other ADG Combinations, Age > 34, 4+ Major ADGs	0	-	$	-	$	-
5010	10+ Other ADG Combinations, Age 1 to 17, no Major ADGs	997	2,175	$	766,696	$	204,252

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Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment

5020	10+ Other ADG Combinations, Age 1 to 17, 1 Major ADGs	1,376	2,812	$	1,412,714	$	497,445
5030	10+ Other ADG Combinations, Age 1 to 17, 2 Major ADGs	1,165	3,488	$	3,066,067	$	957,279
5040	10+ Other ADG Combinations, Age > 17, 0-1 Major ADGs	276	648	$	213,412	$	63,390
5050	10+ Other ADG Combinations, Age > 17, 2 Major ADGs	239	556	$	308,374	$	62,169
5060	10+ Other ADG Combinations, Age > 17, 3 Major ADGs	60	224	$	282,031	$	74,655
5070	10+ Other ADG Combinations, Age > 17, 4+ Major ADGs	44	143	$	199,092	$	46,136
5100	No Diagnosis or Only Unclassified Diagnosis & Non-Users (1 input file)	148	130	$	78,710	$	29,679
5310	Infants: 0-5 ADGs, no Major ADGs	189	194	$	39,441	$	14,608
5320	Infants: 0-5 ADGs, 1+ Major ADGs	11	14	$	14,897	$	5,739
5330	Infants: 6+ ADGs, no Major ADGs	76	146	$	35,487	$	10,573
5340	Infants: 6+ ADGs, 1+ Major ADGs	65	191	$	54,712	$	19,725
9900	Invalid Age or Date of Birth	19	82	$	129,136	$	36,755
Total		157,139	89,259	$	29,892,994	$	9,010,488

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Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment
Disabled

ACG Code	Description	Exposure	Claims	Billed	Paid
0000	No Claim Submitted	78,436	-	$ -	$ -
0100	Acute Minor, Age 1	0	-	$ -	$ -
0200	Acute Minor, Age 2 to 5	80	33	$ 3,748	$ 1,459
0300	Acute Minor, Age > 5	3,707	1,310	$ 216,923	$ 76,270
0400	Acute Major	2,701	953	$ 609,357	$ 125,722
0500	Likely to Recur, w/o Allergies	992	225	$ 77,051	$ 18,719
0600	Likely to Recur, with Allergies	99	41	$ 3,380	$ 1,423
0700	Asthma	74	27	$ 6,329	$ 1,863
0800	Chronic Medical, Unstable	942	682	$ 893,476	$ 296,493
0900	Chronic Medical, Stable	2,049	765	$ 277,968	$ 135,885
1000	Chronic Specialty	85	17	$ 4,346	$ 1,376
1100	Eye/Dental	605	148	$ 66,474	$ 21,522
1200	Chronic Specialty, Unstable	73	14	$ 21,024	$ 4,927
1300	Psychosocial, w/o Psych Unstable	376	133	$ 33,518	$ 9,565
1400	Psychosocial, with Psych Unstable, w/o Psych Stable	310	122	$ 26,718	$ 6,321
1500	Psychosocial, with Psych Unstable, w/ Psych Stable	229	99	$ 33,690	$ 5,004
1600	Preventive/Administrative	1,516	359	$ 79,873	$ 28,099
1710	Pregnancy: 0-1 ADGs	50	23	$ 17,827	$ 5,965
1720	Pregnancy: 2-3 ADGs, no Major ADGs	282	272	$ 200,386	$ 55,709
1730	Pregnancy: 2-3 ADGs, 1+ Major ADGs	49	58	$ 26,880	$ 7,610
1740	Pregnancy: 4-5 ADGs, no Major ADGs	292	451	$ 244,908	$ 85,716
1750	Pregnancy: 4-5 ADGs, 1+ Major ADGs	149	207	$ 198,888	$ 80,577
1760	Pregnancy: 6+ ADGs, no Major ADGs	631	1,378	$ 617,297	$ 198,516
1770	Pregnancy: 6+ ADGs, 1+ Major ADGs	6,675	25,182	$ 19,310,440	$ 7,546,412
1800	Acute Minor and Acute Major	4,866	2,649	$ 1,386,973	$ 419,695
1900	Acute Minor and Likely to Recur, Age 1	7	2	$ 81	$ 48
2000	Acute Minor and Likely to Recur, Age 2 to 5	108	42	$ 5,061	$ 2,493
2100	Acute Minor and Likely to Recur, Age > 5, w/o Allergy	1,937	810	$ 177,833	$ 53,376
2200	Acute Minor and Likely to Recur, Age > 5, with Allergy	589	303	$ 63,153	$ 19,501
2300	Acute Minor and Chronic Medical: Stable	1,944	955	$ 213,392	$ 83,941
2400	Acute Minor and Eye/Dental	359	138	$ 29,347	$ 9,904
2500	Acute Minor and Psychosocial, w/o Psych Unstable	650	255	$ 60,518	$ 18,945
2600	Acute Minor and Psychosocial, with Psych Unstable, w/o Psych Stable	188	130	$ 20,338	$ 5,765
2700	Acute Minor and Psychosocial, with Psych Unstable and Psych Stable	198	101	$ 42,472	$ 7,024

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Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment

2800	Acute Minor and Likely to Recur	1,313	669	$	269,730	$	75,339
2900	Acute Minor/Acute Major/Likely to Recur, Age 1	36	75	$	39,674	$	11,511
3000	Acute Minor/Acute Major/Likely to Recur, Age 2 to 5	225	234	$	100,782	$	24,924
3100	Acute Minor/Acute Major/Likely to Recur, Age 6 to 11	194	187	$	56,788	$	15,501
3200	Acute Minor/Acute Major/Likely to Recur, Age > 11, w/o Allergy	3,795	3,439	$	2,162,159	$	768,604
3300	Acute Minor/Acute Major/Likely to Recur, Age > 11, with Allergy	724	640	$	155,916	$	49,715
3400	Acute Minor/Likely to Recur/Eye & Dental	268	161	$	38,909	$	9,714
3500	Acute Minor/Likely to Recur/Psychosocial	1,082	660	$	145,998	$	41,811
3600	Acute Minor/Acute Major/Likely Recur/Eye & Dental	10,282	15,512	$	6,142,357	$	2,066,566
3700	Acute Minor/Acute Major/Likely Recur/Psychosocial	3,222	4,394	$	2,349,474	$	746,128
3800	2-3 Other ADG Combinations, Age < 18	1,419	733	$	283,450	$	85,406
3900	2-3 Other ADG Combinations, Males Age 18 to 34	2,710	1,296	$	601,981	$	203,378
4000	2-3 Other ADG Combinations, Females Age 18 to 34	1,817	1,018	$	384,579	$	126,791
4100	2-3 Other ADG Combinations, Age > 34	14,871	9,500	$	5,266,571	$	1,766,498
4210	4-5 Other ADG Combinations, Age < 18, no Major ADGs	970	960	$	537,934	$	152,162
4220	4-5 Other ADG Combinations, Age < 18, 1+ Major ADGs	838	932	$	1,020,072	$	391,333
4310	4-5 Other ADG Combinations, Age 18 to 44, no Major ADGs	4,509	3,332	$	984,456	$	310,418
4320	4-5 Other ADG Combinations, Age 18 to 44, 1+ Major ADGs	5,425	5,676	$	3,503,310	$	1,130,751
4330	4-5 Other ADG Combinations, Age 18 to 44, 2+ Major ADGs	1,949	2,471	$	2,072,757	$	909,095
4410	4-5 Other ADG Combinations, Age > 44, no Major ADGs	4,058	3,413	$	782,271	$	263,128
4420	4-5 Other ADG Combinations, Age > 44, 1+ Major ADGs	8,753	9,752	$	4,950,301	$	1,684,736
4430	4-5 Other ADG Combinations, Age > 44, 2+ Major ADGs	3,930	5,318	$	4,569,257	$	1,534,286
4510	6-9 Other ADG Combinations, Age < 6, no Major ADGs	336	653	$	408,221	$	246,880
4520	6-9 Other ADG Combinations, Age < 6, 1+ Major ADGs	765	1,824	$	1,426,798	$	493,948
4610	6-9 Other ADG Combinations, Age 6 to 17, no Major ADGs	824	1,403	$	659,477	$	297,817
4620	6-9 Other ADG Combinations, Age 6 to 17, 1+ Major ADGs	1,414	2,496	$	1,432,379	$	435,358
4710	6-9 Other ADG Combinations, Males, Age 18 to 34, no Major ADGs	1,314	1,615	$	673,303	$	213,254
4720	6-9 Other ADG Combinations, Males, Age 18 to 34, 1+ Major ADGs	2,175	3,619	$	2,133,675	$	994,911
4730	6-9 Other ADG Combinations, Males, Age 18 to 34, 2+ Major ADGs	2,789	5,627	$	6,153,397	$	2,032,650
4810	6-9 Other ADG Combinations, Females, Age 18 to 34, no Major ADGs	1,653	2,513	$	745,425	$	211,683
4820	6-9 Other ADG Combinations, Females, Age 18 to 34, 1+ Major ADGs	2,197	3,435	$	1,481,767	$	464,097
4830	6-9 Other ADG Combinations, Females, Age 18 to 34, 2+ Major ADGs	1,966	4,301	$	3,588,372	$	1,153,529
4910	6-9 Other ADG Combinations, Age > 34, 0-1 Major ADGs	29,255	50,902	$	22,378,846	$	7,200,607
4920	6-9 Other ADG Combinations, Age > 34, 2 Major ADGs	21,749	47,134	$	33,285,459	$	11,101,722
4930	6-9 Other ADG Combinations, Age > 34, 3 Major ADGs	8,851	25,157	$	26,368,773	$	8,112,920
4940	6-9 Other ADG Combinations, Age > 34, 4+ Major ADGs	2,107	7,925	$	11,504,386	$	3,259,934
5010	10+ Other ADG Combinations, Age 1 to 17, no Major ADGs	223	588	$	212,522	$	59,766

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Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment

5020	10+ Other ADG Combinations, Age 1 to 17, 1 Major ADGs	758	2,948	$	1,416,716	$	530,574
5030	10+ Other ADG Combinations, Age 1 to 17, 2 Major ADGs	1,913	9,676	$	9,041,330	$	3,589,844
5040	10+ Other ADG Combinations, Age > 17, 0-1 Major ADGs	13,752	40,053	$	16,383,046	$	4,874,097
5050	10+ Other ADG Combinations, Age > 17, 2 Major ADGs	26,071	91,640	$	51,346,141	$	15,364,402
5060	10+ Other ADG Combinations, Age > 17, 3 Major ADGs	27,720	119,146	$	85,520,276	$	26,035,471
5070	10+ Other ADG Combinations, Age > 17, 4+ Major ADGs	38,685	257,978	$	280,310,705	$	84,133,207
5100	No Diagnosis or Only Unclassified Diagnosis & Non-Users (1 input file)	-989	410	$	767,847	$	193,489
5310	Infants: 0-5 ADGs, no Major ADGs	40	79	$	18,296	$	5,706
5320	Infants: 0-5 ADGs, 1+ Major ADGs	41	321	$	1,081,041	$	205,985
5330	Infants: 6+ ADGs, no Major ADGs	28	87	$	29,724	$	11,475
5340	Infants: 6+ ADGs, 1+ Major ADGs	168	2,362	$	4,926,183	$	1,518,834
9900	Invalid Age or Date of Birth	52	859	$	1,684,418	$	752,040
Total		369,495	793,009	$	626,366,919	$	195,197,844

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Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

John Hopkins' ACG Risk Assessment
Duals

ACG Code	Description	Exposure	Claims	Billed	Paid
0000	No Claim Submitted	528,890	-	$ -	$ -
0100	Acute Minor, Age 1	0	-	$ -	$ -
0200	Acute Minor, Age 2 to 5	0	-	$ -	$ -
0300	Acute Minor, Age > 5	41,991	41,857	$ 2,673,217	$ 2,432,829
0400	Acute Major	6,130	1,168	$ 1,033,255	$ 629,658
0500	Likely to Recur, w/o Allergies	1,949	262	$ 236,319	$ 38,363
0600	Likely to Recur, with Allergies	98	10	$ 43,142	$ 333
0700	Asthma	37	4	$ 147	$ 124
0800	Chronic Medical, Unstable	3,545	1,404	$ 2,693,450	$ 2,351,568
0900	Chronic Medical, Stable	1,967	455	$ 277,283	$ 190,010
1000	Chronic Specialty	160	17	$ 17,236	$ 903
1100	Eye/Dental	890	122	$ 227,895	$ 2,139
1200	Chronic Specialty, Unstable	215	23	$ 18,423	$ 2,727
1300	Psychosocial, w/o Psych Unstable	350	62	$ 19,230	$ 7,357
1400	Psychosocial, with Psych Unstable, w/o Psych Stable	911	393	$ 1,038,990	$ 1,016,666
1500	Psychosocial, with Psych Unstable, w/ Psych Stable	66	8	$ 9,614	$ 690
1600	Preventive/Administrative	3,291	569	$ 125,022	$ 89,914
1710	Pregnancy: 0-1 ADGs	86	18	$ 3,637	$ 1,581
1720	Pregnancy: 2-3 ADGs, no Major ADGs	136	36	$ 17,544	$ 5,167
1730	Pregnancy: 2-3 ADGs, 1+ Major ADGs	35	8	$ 1,708	$ 577
1740	Pregnancy: 4-5 ADGs, no Major ADGs	71	54	$ 21,996	$ 6,376
1750	Pregnancy: 4-5 ADGs, 1+ Major ADGs	65	20	$ 6,548	$ 2,811
1760	Pregnancy: 6+ ADGs, no Major ADGs	98	57	$ 30,418	$ 4,217
1770	Pregnancy: 6+ ADGs, 1+ Major ADGs	534	1,857	$ 1,258,329	$ 641,672
1800	Acute Minor and Acute Major	9,766	8,377	$ 1,209,071	$ 693,982
1900	Acute Minor and Likely to Recur, Age 1	0	-	$ -	$ -
2000	Acute Minor and Likely to Recur, Age 2 to 5	0	-	$ -	$ -
2100	Acute Minor and Likely to Recur, Age > 5, w/o Allergy	3,137	2,304	$ 299,978	$ 160,668
2200	Acute Minor and Likely to Recur, Age > 5, with Allergy	473	212	$ 34,660	$ 18,398
2300	Acute Minor and Chronic Medical: Stable	3,876	2,871	$ 364,160	$ 231,617
2400	Acute Minor and Eye/Dental	745	764	$ 68,426	$ 39,473
2500	Acute Minor and Psychosocial, w/o Psych Unstable	482	191	$ 27,878	$ 18,554
2600	Acute Minor and Psychosocial, with Psych Unstable, w/o Psych Stable	498	209	$ 70,141	$ 61,421
2700	Acute Minor and Psychosocial, with Psych Unstable and Psych Stable	44	15	$ 1,585	$ 409

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2800	Acute Minor and Likely to Recur	1,734	282	$	299,884	$	66,976
2900	Acute Minor/Acute Major/Likely to Recur, Age 1	0	-	$	-	$	-
3000	Acute Minor/Acute Major/Likely to Recur, Age 2 to 5	0	-	$	-	$	-
3100	Acute Minor/Acute Major/Likely to Recur, Age 6 to 11	0	-	$	-	$	-
3200	Acute Minor/Acute Major/Likely to Recur, Age > 11, w/o Allergy	3,664	2,540	$	487,902	$	194,482
3300	Acute Minor/Acute Major/Likely to Recur, Age > 11, with Allergy	268	182	$	27,337	$	16,782
3400	Acute Minor/Likely to Recur/Eye & Dental	189	117	$	23,998	$	7,532
3500	Acute Minor/Likely to Recur/Psychosocial	362	176	$	30,635	$	12,915
3600	Acute Minor/Acute Major/Likely Recur/Eye & Dental	4,157	3,245	$	1,266,829	$	585,830
3700	Acute Minor/Acute Major/Likely Recur/Psychosocial	820	596	$	269,190	$	83,632
3800	2-3 Other ADG Combinations, Age < 18	0	-	$	-	$	-
3900	2-3 Other ADG Combinations, Males Age 18 to 34	1,050	657	$	267,493	$	147,375
4000	2-3 Other ADG Combinations, Females Age 18 to 34	872	493	$	144,252	$	60,832
4100	2-3 Other ADG Combinations, Age > 34	34,086	24,527	$	11,061,983	$	6,955,682
4210	4-5 Other ADG Combinations, Age < 18, no Major ADGs	11	4	$	228	$	145
4220	4-5 Other ADG Combinations, Age < 18, 1+ Major ADGs	0	-	$	-	$	-
4310	4-5 Other ADG Combinations, Age 18 to 44, no Major ADGs	1,586	942	$	287,531	$	85,242
4320	4-5 Other ADG Combinations, Age 18 to 44, 1+ Major ADGs	2,772	2,190	$	705,507	$	238,198
4330	4-5 Other ADG Combinations, Age 18 to 44, 2+ Major ADGs	1,290	1,276	$	844,634	$	599,681
4410	4-5 Other ADG Combinations, Age > 44, no Major ADGs	4,206	2,537	$	719,195	$	231,676
4420	4-5 Other ADG Combinations, Age > 44, 1+ Major ADGs	12,517	12,225	$	5,547,932	$	3,397,812
4430	4-5 Other ADG Combinations, Age > 44, 2+ Major ADGs	8,592	8,157	$	4,655,369	$	2,849,838
4510	6-9 Other ADG Combinations, Age < 6, no Major ADGs	0	-	$	-	$	-
4520	6-9 Other ADG Combinations, Age < 6, 1+ Major ADGs	0	-	$	-	$	-
4610	6-9 Other ADG Combinations, Age 6 to 17, no Major ADGs	0	-	$	-	$	-
4620	6-9 Other ADG Combinations, Age 6 to 17, 1+ Major ADGs	0	-	$	-	$	-
4710	6-9 Other ADG Combinations, Males, Age 18 to 34, no Major ADGs	22	9	$	5,189	$	596
4720	6-9 Other ADG Combinations, Males, Age 18 to 34, 1+ Major ADGs	368	441	$	585,500	$	332,326
4730	6-9 Other ADG Combinations, Males, Age 18 to 34, 2+ Major ADGs	451	634	$	504,596	$	346,868
4810	6-9 Other ADG Combinations, Females, Age 18 to 34, no Major ADGs	220	134	$	65,386	$	9,195
4820	6-9 Other ADG Combinations, Females, Age 18 to 34, 1+ Major ADGs	343	238	$	111,078	$	38,962
4830	6-9 Other ADG Combinations, Females, Age 18 to 34, 2+ Major ADGs	500	832	$	733,715	$	146,888
4910	6-9 Other ADG Combinations, Age > 34, 0-1 Major ADGs	10,971	10,781	$	4,279,843	$	1,635,900
4920	6-9 Other ADG Combinations, Age > 34, 2 Major ADGs	10,199	11,818	$	5,758,039	$	2,517,569
4930	6-9 Other ADG Combinations, Age > 34, 3 Major ADGs	5,338	7,325	$	4,933,826	$	2,801,940
4940	6-9 Other ADG Combinations, Age > 34, 4+ Major ADGs	1,444	2,535	$	2,811,288	$	1,744,362
5010	10+ Other ADG Combinations, Age 1 to 17, no Major ADGs	5	6	$	1,007	$	363

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5020	10+ Other ADG Combinations, Age 1 to 17, 1 Major ADGs	0	-	$	-	$	-
5030	10+ Other ADG Combinations, Age 1 to 17, 2 Major ADGs	13	7	$	6,543	$	3,430
5040	10+ Other ADG Combinations, Age > 17, 0-1 Major ADGs	1,580	2,197	$	934,191	$	234,117
5050	10+ Other ADG Combinations, Age > 17, 2 Major ADGs	3,344	6,002	$	2,494,309	$	684,459
5060	10+ Other ADG Combinations, Age > 17, 3 Major ADGs	3,457	6,766	$	4,306,688	$	1,533,761
5070	10+ Other ADG Combinations, Age > 17, 4+ Major ADGs	4,769	13,792	$	10,396,157	$	3,714,269
5100	No Diagnosis or Only Unclassified Diagnosis & Non-Users (1 input file)	15,593	508	$	537,140	$	157,521
5310	Infants: 0-5 ADGs, no Major ADGs	0	-	$	-	$	-
5320	Infants: 0-5 ADGs, 1+ Major ADGs	0	-	$	-	$	-
5330	Infants: 6+ ADGs, no Major ADGs	0	-	$	-	$	-
5340	Infants: 6+ ADGs, 1+ Major ADGs	0	-	$	-	$	-
9900	Invalid Age or Date of Birth	0	-	$	-	$	-
Total		747,329	187,520	$	76,933,691	$	40,087,358

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Waiver Duals

ACG Code	Description	Exposure	Claims	Billed	Paid
0000	No Claim Submitted	16,517	-	$ -	$ -
0100	Acute Minor, Age 1	0	-	$ -	$ -
0200	Acute Minor, Age 2 to 5	0	-	$ -	$ -
0300	Acute Minor, Age > 5	380	408	$ 21,168	$ 20,384
0400	Acute Major	108	17	$ 32,612	$ 971
0500	Likely to Recur, w/o Allergies	22	5	$ 5,898	$ 70
0600	Likely to Recur, with Allergies	0	-	$ -	$ -
0700	Asthma	0	-	$ -	$ -
0800	Chronic Medical, Unstable	57	18	$ 20,469	$ 12,611
0900	Chronic Medical, Stable	42	8	$ 5,904	$ 284
1000	Chronic Specialty	0	-	$ -	$ -
1100	Eye/Dental	18	3	$ 3,850	$ 54
1200	Chronic Specialty, Unstable	0	-	$ -	$ -
1300	Psychosocial, w/o Psych Unstable	0	-	$ -	$ -
1400	Psychosocial, with Psych Unstable, w/o Psych Stable	0	-	$ -	$ -
1500	Psychosocial, with Psych Unstable, w/ Psych Stable	0	-	$ -	$ -
1600	Preventive/Administrative	19	4	$ 974	$ 445
1710	Pregnancy: 0-1 ADGs	0	-	$ -	$ -
1720	Pregnancy: 2-3 ADGs, no Major ADGs	10	10	$ 1,600	$ 387
1730	Pregnancy: 2-3 ADGs, 1+ Major ADGs	0	-	$ -	$ -
1740	Pregnancy: 4-5 ADGs, no Major ADGs	0	-	$ -	$ -
1750	Pregnancy: 4-5 ADGs, 1+ Major ADGs	0	-	$ -	$ -
1760	Pregnancy: 6+ ADGs, no Major ADGs	0	-	$ -	$ -
1770	Pregnancy: 6+ ADGs, 1+ Major ADGs	0	-	$ -	$ -
1800	Acute Minor and Acute Major	130	74	$ 11,521	$ 5,614
1900	Acute Minor and Likely to Recur, Age 1	0	-	$ -	$ -
2000	Acute Minor and Likely to Recur, Age 2 to 5	0	-	$ -	$ -
2100	Acute Minor and Likely to Recur, Age > 5, w/o Allergy	28	18	$ 968	$ 832
2200	Acute Minor and Likely to Recur, Age > 5, with Allergy	0	-	$ -	$ -
2300	Acute Minor and Chronic Medical: Stable	23	24	$ 2,688	$ 1,676
2400	Acute Minor and Eye/Dental	11	3	$ 287	$ 60
2500	Acute Minor and Psychosocial, w/o Psych Unstable	5	2	$ 392	$ 340
2600	Acute Minor and Psychosocial, with Psych Unstable, w/o Psych Stable	6	7	$ 130	$ 130
2700	Acute Minor and Psychosocial, with Psych Unstable and Psych Stable	0	-	$ -	$ -

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2800	Acute Minor and Likely to Recur	18	5	$	3,786	$	170
2900	Acute Minor/Acute Major/Likely to Recur, Age 1	0	-	$	-	$	-
3000	Acute Minor/Acute Major/Likely to Recur, Age 2 to 5	0	-	$	-	$	-
3100	Acute Minor/Acute Major/Likely to Recur, Age 6 to 11	0	-	$	-	$	-
3200	Acute Minor/Acute Major/Likely to Recur, Age > 11, w/o Allergy	37	13	$	6,395	$	306
3300	Acute Minor/Acute Major/Likely to Recur, Age > 11, with Allergy	0	-	$	-	$	-
3400	Acute Minor/Likely to Recur/Eye & Dental	0	-	$	-	$	-
3500	Acute Minor/Likely to Recur/Psychosocial	0	-	$	-	$	-
3600	Acute Minor/Acute Major/Likely Recur/Eye & Dental	71	16	$	9,224	$	556
3700	Acute Minor/Acute Major/Likely Recur/Psychosocial	0	-	$	-	$	-
3800	2-3 Other ADG Combinations, Age < 18	0	-	$	-	$	-
3900	2-3 Other ADG Combinations, Males Age 18 to 34	6	1	$	80	$	51
4000	2-3 Other ADG Combinations, Females Age 18 to 34	4	2	$	6,781	$	5,026
4100	2-3 Other ADG Combinations, Age > 34	566	228	$	185,676	$	60,191
4210	4-5 Other ADG Combinations, Age < 18, no Major ADGs	0	-	$	-	$	-
4220	4-5 Other ADG Combinations, Age < 18, 1+ Major ADGs	0	-	$	-	$	-
4310	4-5 Other ADG Combinations, Age 18 to 44, no Major ADGs	16	2	$	149	$	52
4320	4-5 Other ADG Combinations, Age 18 to 44, 1+ Major ADGs	24	16	$	12,995	$	962
4330	4-5 Other ADG Combinations, Age 18 to 44, 2+ Major ADGs	6	11	$	1,035	$	1,036
4410	4-5 Other ADG Combinations, Age > 44, no Major ADGs	86	35	$	25,406	$	12,505
4420	4-5 Other ADG Combinations, Age > 44, 1+ Major ADGs	256	193	$	73,489	$	13,581
4430	4-5 Other ADG Combinations, Age > 44, 2+ Major ADGs	174	53	$	43,852	$	4,322
4510	6-9 Other ADG Combinations, Age < 6, no Major ADGs	0	-	$	-	$	-
4520	6-9 Other ADG Combinations, Age < 6, 1+ Major ADGs	0	-	$	-	$	-
4610	6-9 Other ADG Combinations, Age 6 to 17, no Major ADGs	0	-	$	-	$	-
4620	6-9 Other ADG Combinations, Age 6 to 17, 1+ Major ADGs	0	-	$	-	$	-
4710	6-9 Other ADG Combinations, Males, Age 18 to 34, no Major ADGs	0	-	$	-	$	-
4720	6-9 Other ADG Combinations, Males, Age 18 to 34, 1+ Major ADGs	0	-	$	-	$	-
4730	6-9 Other ADG Combinations, Males, Age 18 to 34, 2+ Major ADGs	0	-	$	-	$	-
4810	6-9 Other ADG Combinations, Females, Age 18 to 34, no Major ADGs	0	-	$	-	$	-
4820	6-9 Other ADG Combinations, Females, Age 18 to 34, 1+ Major ADGs	0	-	$	-	$	-
4830	6-9 Other ADG Combinations, Females, Age 18 to 34, 2+ Major ADGs	2	3	$	1,015	$	221
4910	6-9 Other ADG Combinations, Age > 34, 0-1 Major ADGs	208	250	$	86,890	$	28,489
4920	6-9 Other ADG Combinations, Age > 34, 2 Major ADGs	214	134	$	102,487	$	9,958
4930	6-9 Other ADG Combinations, Age > 34, 3 Major ADGs	122	95	$	188,836	$	18,151
4940	6-9 Other ADG Combinations, Age > 34, 4+ Major ADGs	20	15	$	7,367	$	1,630
5010	10+ Other ADG Combinations, Age 1 to 17, no Major ADGs	0	-	$	-	$	-

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5020	10+ Other ADG Combinations, Age 1 to 17, 1 Major ADGs	0	-	$	-	$	-
5030	10+ Other ADG Combinations, Age 1 to 17, 2 Major ADGs	0	-	$	-	$	-
5040	10+ Other ADG Combinations, Age > 17, 0-1 Major ADGs	30	30	$	15,369	$	2,903
5050	10+ Other ADG Combinations, Age > 17, 2 Major ADGs	46	139	$	29,944	$	9,551
5060	10+ Other ADG Combinations, Age > 17, 3 Major ADGs	91	116	$	41,263	$	9,196
5070	10+ Other ADG Combinations, Age > 17, 4+ Major ADGs	86	90	$	94,439	$	34,722
5100	No Diagnosis or Only Unclassified Diagnosis & Non-Users (1 input file)	532	13	$	(94)	$	26
5310	Infants: 0-5 ADGs, no Major ADGs	0	-	$	-	$	-
5320	Infants: 0-5 ADGs, 1+ Major ADGs	0	-	$	-	$	-
5330	Infants: 6+ ADGs, no Major ADGs	0	-	$	-	$	-
5340	Infants: 6+ ADGs, 1+ Major ADGs	0	-	$	-	$	-
9900	Invalid Age or Date of Birth	0	-	$	-	$	-
Total		19,989	2,061	$	1,044,847	$	257,460

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John Hopkins' ACG Risk Assessment
All Categories

ACG Code	Description	Exposure	Claims	Billed	Paid
0000	No Claim Submitted	1,139,899	-	$ -	$ -
0100	Acute Minor, Age 1	12,935	6,316	$ 1,011,447	$ 402,715
0200	Acute Minor, Age 2 to 5	61,486	18,904	$ 3,074,405	$ 1,149,405
0300	Acute Minor, Age > 5	169,372	76,000	$ 8,968,018	$ 4,538,699
0400	Acute Major	43,752	13,742	$ 7,228,782	$ 2,199,909
0500	Likely to Recur, w/o Allergies	50,310	12,509	$ 3,001,253	$ 974,039
0600	Likely to Recur, with Allergies	10,457	2,875	$ 513,513	$ 179,712
0700	Asthma	2,739	619	$ 106,868	$ 41,942
0800	Chronic Medical, Unstable	6,724	3,175	$ 4,238,493	$ 2,877,441
0900	Chronic Medical, Stable	13,982	3,982	$ 1,099,775	$ 515,567
1000	Chronic Specialty	674	187	$ 57,362	$ 15,716
1100	Eye/Dental	46,960	8,847	$ 1,999,857	$ 849,370
1200	Chronic Specialty, Unstable	1,020	209	$ 85,350	$ 24,781
1300	Psychosocial, w/o Psych Unstable	9,360	2,842	$ 488,957	$ 182,097
1400	Psychosocial, with Psych Unstable, w/o Psych Stable	1,670	638	$ 1,169,793	$ 1,101,660
1500	Psychosocial, with Psych Unstable, w/ Psych Stable	575	188	$ 70,246	$ 9,959
1600	Preventive/Administrative	93,977	16,682	$ 2,348,216	$ 1,280,214
1710	Pregnancy: 0-1 ADGs	8,753	10,433	$ 7,746,597	$ 2,811,727
1720	Pregnancy: 2-3 ADGs, no Major ADGs	23,400	31,654	$ 20,510,989	$ 7,086,826
1730	Pregnancy: 2-3 ADGs, 1+ Major ADGs	4,120	5,756	$ 5,800,852	$ 2,142,748
1740	Pregnancy: 4-5 ADGs, no Major ADGs	25,918	41,453	$ 25,084,691	$ 8,371,950
1750	Pregnancy: 4-5 ADGs, 1+ Major ADGs	12,507	20,122	$ 16,056,838	$ 5,538,265
1760	Pregnancy: 6+ ADGs, no Major ADGs	39,343	85,018	$ 46,217,475	$ 14,490,581
1770	Pregnancy: 6+ ADGs, 1+ Major ADGs	106,662	303,277	$ 235,120,051	$ 77,520,233
1800	Acute Minor and Acute Major	127,171	73,759	$ 29,560,151	$ 8,470,810
1900	Acute Minor and Likely to Recur, Age 1	33,287	26,940	$ 4,683,548	$ 1,745,100
2000	Acute Minor and Likely to Recur, Age 2 to 5	90,860	46,874	$ 7,808,105	$ 2,875,243
2100	Acute Minor and Likely to Recur, Age > 5, w/o Allergy	84,385	35,708	$ 6,881,091	$ 2,337,022
2200	Acute Minor and Likely to Recur, Age > 5, with Allergy	32,139	14,923	$ 2,463,748	$ 941,756
2300	Acute Minor and Chronic Medical: Stable	21,194	10,333	$ 1,906,345	$ 763,544
2400	Acute Minor and Eye/Dental	38,923	15,703	$ 2,889,548	$ 1,144,380
2500	Acute Minor and Psychosocial, w/o Psych Unstable	15,295	6,775	$ 1,368,201	$ 446,361
2600	Acute Minor and Psychosocial, with Psych Unstable, w/o Psych Stable	1,207	515	$ 124,632	$ 76,680
2700	Acute Minor and Psychosocial, with Psych Unstable and Psych Stable	510	257	$ 80,822	$ 16,370

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2800	Acute Minor and Likely to Recur	24,814	11,056	$ 4,853,103	$ 1,348,548
2900	Acute Minor/Acute Major/Likely to Recur, Age 1	26,169	32,870	$ 8,441,217	$ 2,678,828
3000	Acute Minor/Acute Major/Likely to Recur, Age 2 to 5	60,448	51,512	$ 13,396,817	$ 4,063,953
3100	Acute Minor/Acute Major/Likely to Recur, Age 6 to 11	41,932	31,461	$ 9,367,623	$ 2,639,766
3200	Acute Minor/Acute Major/Likely to Recur, Age > 11, w/o Allergy	64,265	55,375	$ 23,939,444	$ 6,535,965
3300	Acute Minor/Acute Major/Likely to Recur, Age > 11, with Allergy	16,988	15,521	$ 4,681,137	$ 1,304,931
3400	Acute Minor/Likely to Recur/Eye & Dental	45,565	28,288	$ 5,703,925	$ 2,034,222
3500	Acute Minor/Likely to Recur/Psychosocial	21,740	14,446	$ 2,882,038	$ 997,235
3600	Acute Minor/Acute Major/Likely Recur/Eye & Dental	83,846	106,296	$ 47,407,873	$ 12,859,268
3700	Acute Minor/Acute Major/Likely Recur/Psychosocial	48,185	57,080	$ 22,657,291	$ 6,290,172
3800	2-3 Other ADG Combinations, Age < 18	100,786	41,606	$ 11,631,560	$ 3,724,444
3900	2-3 Other ADG Combinations, Males Age 18 to 34	11,859	5,646	$ 2,996,058	$ 905,606
4000	2-3 Other ADG Combinations, Females Age 18 to 34	22,362	11,442	$ 4,107,953	$ 1,243,290
4100	2-3 Other ADG Combinations, Age > 34	71,538	46,524	$ 22,122,514	$ 10,413,984
4210	4-5 Other ADG Combinations, Age < 18, no Major ADGs	106,960	74,646	$ 18,301,843	$ 5,914,287
4220	4-5 Other ADG Combinations, Age < 18, 1+ Major ADGs	34,997	25,261	$ 10,632,212	$ 3,069,861
4310	4-5 Other ADG Combinations, Age 18 to 44, no Major ADGs	38,368	28,612	$ 9,222,748	$ 2,588,319
4320	4-5 Other ADG Combinations, Age 18 to 44, 1+ Major ADGs	29,438	25,928	$ 13,139,920	$ 3,794,304
4330	4-5 Other ADG Combinations, Age 18 to 44, 2+ Major ADGs	8,641	8,952	$ 7,700,735	$ 2,831,651
4410	4-5 Other ADG Combinations, Age > 44, no Major ADGs	12,766	9,591	$ 2,617,890	$ 835,664
4420	4-5 Other ADG Combinations, Age > 44, 1+ Major ADGs	27,852	29,112	$ 14,891,960	$ 6,449,721
4430	4-5 Other ADG Combinations, Age > 44, 2+ Major ADGs	15,194	16,809	$ 12,961,546	$ 5,452,904
4510	6-9 Other ADG Combinations, Age < 6, no Major ADGs	41,399	51,273	$ 13,794,874	$ 4,444,538
4520	6-9 Other ADG Combinations, Age < 6, 1+ Major ADGs	31,815	42,339	$ 17,048,512	$ 4,900,148
4610	6-9 Other ADG Combinations, Age 6 to 17, no Major ADGs	75,269	87,897	$ 24,346,941	$ 7,407,535
4620	6-9 Other ADG Combinations, Age 6 to 17, 1+ Major ADGs	40,636	48,105	$ 24,124,129	$ 7,106,491
4710	6-9 Other ADG Combinations, Males, Age 18 to 34, no Major ADGs	5,012	5,759	$ 2,256,372	$ 625,103
4720	6-9 Other ADG Combinations, Males, Age 18 to 34, 1+ Major ADGs	9,078	13,022	$ 7,443,450	$ 2,554,934
4730	6-9 Other ADG Combinations, Males, Age 18 to 34, 2+ Major ADGs	9,076	16,750	$ 17,079,024	$ 5,927,053
4810	6-9 Other ADG Combinations, Females, Age 18 to 34, no Major ADGs	28,501	38,657	$ 13,417,327	$ 3,596,739
4820	6-9 Other ADG Combinations, Females, Age 18 to 34, 1+ Major ADGs	28,993	41,694	$ 18,825,590	$ 5,164,248
4830	6-9 Other ADG Combinations, Females, Age 18 to 34, 2+ Major ADGs	15,285	24,743	$ 17,498,302	$ 5,016,970
4910	6-9 Other ADG Combinations, Age > 34, 0-1 Major ADGs	83,811	127,085	$ 57,064,730	$ 17,290,743
4920	6-9 Other ADG Combinations, Age > 34, 2 Major ADGs	52,529	97,190	$ 66,097,018	$ 21,223,522
4930	6-9 Other ADG Combinations, Age > 34, 3 Major ADGs	20,371	46,478	$ 46,406,777	$ 15,294,732
4940	6-9 Other ADG Combinations, Age > 34, 4+ Major ADGs	4,549	13,748	$ 19,773,940	$ 6,515,622
5010	10+ Other ADG Combinations, Age 1 to 17, no Major ADGs	15,953	32,392	$ 9,881,065	$ 2,912,028

TennCare **Exhibit 23**

Middle Tennessee Data Book

Historical Encounter Data - Fiscal Year 2005

		John Hopkins' ACG Risk Assessment				
5020	10+ Other ADG Combinations, Age 1 to 17, 1 Major ADGs	21,297	43,535	$	17,233,130	$ 5,227,224
5030	10+ Other ADG Combinations, Age 1 to 17, 2 Major ADGs	19,141	47,972	$	42,094,014	$ 12,942,180
5040	10+ Other ADG Combinations, Age > 17, 0-1 Major ADGs	56,106	146,061	$	65,456,910	$ 17,722,655
5050	10+ Other ADG Combinations, Age > 17, 2 Major ADGs	73,418	229,999	$	129,959,950	$ 36,957,392
5060	10+ Other ADG Combinations, Age > 17, 3 Major ADGs	64,319	246,936	$	172,979,440	$ 50,403,762
5070	10+ Other ADG Combinations, Age > 17, 4+ Major ADGs	71,471	421,160	$	449,237,090	$ 134,301,736
5100	No Diagnosis or Only Unclassified Diagnosis & Non-Users (1 input file)	17,012	4,813	$	3,814,181	$ 881,818
5310	Infants: 0-5 ADGs, no Major ADGs	67,589	70,057	$	15,436,868	$ 5,699,200
5320	Infants: 0-5 ADGs, 1+ Major ADGs	5,716	7,987	$	8,997,726	$ 3,507,912
5330	Infants: 6+ ADGs, no Major ADGs	23,627	47,471	$	13,078,118	$ 4,437,027
5340	Infants: 6+ ADGs, 1+ Major ADGs	20,075	54,230	$	49,758,925	$ 18,508,780
9900	Invalid Age or Date of Birth	13,101	27,941	$	33,051,779	$ 13,646,463
Grand Total		**4,161,436**	**3,660,543**	**$**	**2,079,579,606**	**$ 655,316,300**

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE							
Reporting Month							2003
Feb-06							Incurred Month
	January	February	March	April	May	June	July
Enrollment	186,440	189,964	197,245	196,492	198,328	296,648	299,642
Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 11,461,349	$ 12,114,445	$ 12,633,424	$ 11,821,862	$ 13,374,304	$ 17,719,849	$ 18,477,961
HCFA1500 Payments by the Claims Processing System	11,220,820	11,042,876	12,167,999	12,237,256	12,161,666	17,365,640	18,940,949
Dental Payments by the Claims Processing System	1,690	0	0	0	0	0	0
Capitation Payments	2,404,449	2,255,606	2,230,814	1,844,055	1,921,067	2,331,484	2,760,566
Pharmacy Payments	845,206	841,821	901,815	897,356	915,175	886,878	628
Subcontractor Payments for Medical Services	5,812,891	5,744,090	6,381,260	6,499,787	6,728,230	11,278,055	0
Reinsurance Payment	0	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	85,174	(50,978)	53,776	9,985	(6,077)	66,326	(57)
Less:	0	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0	0
Pharmacy Rebates	442,697	442,694	443,972	453,028	453,437	452,784	0
Recoveries not in Claims Payments	65,035	68,730	122,002	69,050	85,098	129,040	42,581
Total Payments for the month	31,323,846	31,436,437	33,803,113	32,788,222	34,555,830	49,066,408	40,137,466
Remaining IBNR for the month	0	0	0	0	0	0	0
Payments and Remaining IBNR for the month	**31,323,846**	**31,436,437**	**33,803,113**	**32,788,222**	**34,555,830**	**49,066,408**	**40,137,466**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 61.47	$ 63.77	$ 64.05	$ 60.16	$ 67.44	$ 59.73	$ 61.67
HCFA1500 Payments by the Claims Processing System	$ 60.18	$ 58.13	$ 61.69	$ 62.28	$ 61.32	$ 58.54	$ 63.21
Dental Payments by the Claims Processing System	$ 0.01	$ -	$ -	$ -	$ -	$ -	$ -
Capitation Payments	$ 12.90	$ 11.87	$ 11.31	$ 9.38	$ 9.69	$ 7.86	$ 9.21
Other Payments/Adjustments to Medical Costs	$ 0.46	$ (0.27)	$ 0.27	$ 0.05	$ (0.03)	$ 0.22	$ (0.00)
Recoveries not in Claims Payments	$ (0.35)	$ (0.36)	$ (0.62)	$ (0.35)	$ (0.43)	$ (0.43)	$ (0.14)
Total Payments for the month	$ 134.67	$ 133.15	$ 136.70	$ 131.53	$ 137.98	$ 125.92	$ 133.95
Remaining IBNR for the month	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Payments and Remaining IBNR for the month	**$ 134.67**	**$ 133.15**	**$ 136.70**	**$ 131.53**	**$ 137.98**	**$ 125.92**	**$ 133.95**

Annual Trend

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE

Reporting Month							
Feb-06							
	August	September	October	November	December	January	February
Enrollment	426,613	450,733	447,141	422,251	422,599	424,214	425,670
Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 27,945,591	$ 27,089,315	$ 28,586,252	$ 26,807,498	$ 32,058,278	$ 33,343,230	$ 32,228,049
HCFA1500 Payments by the Claims Processing System	27,300,378	28,042,650	29,306,913	25,689,824	28,881,951	29,175,063	28,411,864
Dental Payments by the Claims Processing System	0	0	0	0	0	0	0
Capitation Payments	4,040,469	3,869,670	3,740,204	3,983,903	3,697,421	4,001,988	4,087,975
Pharmacy Payments	1,159	1,340	252	2,448	201	0	0
Subcontractor Payments for Medical Services	0	0	0	0	0	0	0
Reinsurance Payment	0	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	304,638	(9,004)	(6,915)	4,195	(34,921)	102,318	37,548
Less:	0	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0	0
Pharmacy Rebates	0	0	0	0	0	0	0
Recoveries not in Claims Payments	67,021	149,110	24,999	61,666	94,084	160,984	96,795
Total Payments for the month	59,525,215	58,844,861	61,601,708	56,426,202	64,508,846	66,461,615	64,668,642
Remaining IBNR for the month	0	0	0	0	0	0	0
Payments and Remaining IBNR for the month	**59,525,215**	**58,844,861**	**61,601,708**	**56,426,202**	**64,508,846**	**66,461,615**	**64,668,642**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 65.51	$ 60.10	$ 63.93	$ 63.49	$ 75.86	$ 78.60	$ 75.71
HCFA1500 Payments by the Claims Processing System	$ 63.99	$ 62.22	$ 65.54	$ 60.84	$ 68.34	$ 68.77	$ 66.75
Dental Payments by the Claims Processing System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capitation Payments	$ 9.47	$ 8.59	$ 8.36	$ 9.43	$ 8.75	$ 9.43	$ 9.60
Other Payments/Adjustments to Medical Costs	$ 0.71	$ (0.02)	$ (0.02)	$ 0.01	$ (0.08)	$ 0.24	$ 0.09
Recoveries not in Claims Payments	$ (0.16)	$ (0.33)	$ (0.06)	$ (0.15)	$ (0.22)	$ (0.38)	$ (0.23)
Total Payments for the month	$ 139.53	$ 130.55	$ 137.77	$ 133.63	$ 152.65	$ 156.67	$ 151.92
Remaining IBNR for the month	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Payments and Remaining IBNR for the month	**$ 139.53**	**$ 130.55**	**$ 137.77**	**$ 133.63**	**$ 152.65**	**$ 156.67**	**$ 151.92**
Annual Trend						16%	14%

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE

Reporting Month	2004						
Feb-06	Incurred Month						
	March	April	May	June	July	August	September
Enrollment	428,369	430,007	430,103	428,981	428,313	428,637	430,164
Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 35,619,402	$ 33,429,827	$ 34,408,099	$ 36,178,955	$ 38,720,459	$ 41,300,862	$ 39,753,228
HCFA1500 Payments by the Claims Processing System	32,441,354	30,659,071	29,553,780	31,245,988	31,748,248	34,785,379	34,206,673
Dental Payments by the Claims Processing System	0	0	0	0	0	0	0
Capitation Payments	4,087,237	4,077,920	3,851,586	5,113,439	1,221,852	1,230,379	1,343,508
Pharmacy Payments	0	0	0	0	0	0	0
Subcontractor Payments for Medical Services	0	0	0	0	0	0	0
Reinsurance Payment	0	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	(20,465)	26,194	(498,767)	146,056	(174,114)	8,039	45,567
Less:	0	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0	0
Pharmacy Rebates	0	0	0	0	0	0	0
Recoveries not in Claims Payments	71,841	103,957	101,226	93,547	83,183	127,470	94,647
Total Payments for the month	72,055,687	68,089,055	67,213,472	72,590,891	71,433,263	77,197,189	75,254,329
Remaining IBNR for the month	0	0	0	0	0	0	8,543
Payments and Remaining IBNR for the month	**72,055,687**	**68,089,055**	**67,213,472**	**72,590,891**	**71,433,263**	**77,197,189**	**75,262,872**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 83.15	$ 77.74	$ 80.00	$ 84.34	$ 90.40	$ 96.35	$ 92.41
HCFA1500 Payments by the Claims Processing System	$ 75.73	$ 71.30	$ 68.71	$ 72.84	$ 74.12	$ 81.15	$ 79.52
Dental Payments by the Claims Processing System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capitation Payments	$ 9.54	$ 9.48	$ 8.96	$ 11.92	$ 2.85	$ 2.87	$ 3.12
Other Payments/Adjustments to Medical Costs	$ (0.05)	$ 0.06	$ (1.16)	$ 0.34	$ (0.41)	$ 0.02	$ 0.11
Recoveries not in Claims Payments	$ (0.17)	$ (0.24)	$ (0.24)	$ (0.22)	$ (0.19)	$ (0.30)	$ (0.22)
Total Payments for the month	$ 168.21	$ 158.34	$ 156.27	$ 169.22	$ 166.78	$ 180.10	$ 174.94
Remaining IBNR for the month	$ -	$ -	$ -	$ -	$ -	$ -	$ 0.02
Payments and Remaining IBNR for the month	**$ 168.21**	**$ 158.34**	**$ 156.27**	**$ 169.22**	**$ 166.78**	**$ 180.10**	**$ 174.96**
Annual Trend	23%	20%	13%	34%	25%	29%	34%

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE

Reporting Month							
Feb-06							
	October	November	December	January	February	March	April
Enrollment	434,913	429,918	428,832	427,504	426,889	426,634	427,960
Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 38,242,075	$ 39,747,455	$ 38,257,086	$ 40,933,742	$ 37,230,241	$ 42,221,999	$ 38,590,740
HCFA1500 Payments by the Claims Processing System	33,559,375	34,180,768	33,283,289	36,551,531	35,093,374	38,800,705	36,274,511
Dental Payments by the Claims Processing System	0	0	0	0	0	0	0
Capitation Payments	1,119,192	1,591,761	1,605,007	1,157,004	1,222,054	1,126,376	1,118,525
Pharmacy Payments	0	0	0	0	0	0	0
Subcontractor Payments for Medical Services	0	0	0	0	0	0	0
Reinsurance Payment	0	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	(10,127)	(4,277)	247,780	79,659	612,101	250,058	(21,138)
Less:	0	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0	0
Pharmacy Rebates	0	0	0	0	0	0	0
Recoveries not in Claims Payments	97,885	88,944	243,156	47,372	98,236	148,215	236,920
Total Payments for the month	72,812,631	75,426,763	73,150,005	78,674,563	74,059,534	82,250,923	75,725,718
Remaining IBNR for the month	17,590	35,652	55,701	69,065	99,695	208,783	370,072
Payments and Remaining IBNR for the month	**72,830,221**	**75,462,415**	**73,205,706**	**78,743,628**	**74,159,230**	**82,459,706**	**76,095,790**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 87.93	$ 92.45	$ 89.21	$ 95.75	$ 87.21	$ 98.97	$ 90.17
HCFA1500 Payments by the Claims Processing System	$ 77.16	$ 79.51	$ 77.61	$ 85.50	$ 82.21	$ 90.95	$ 84.76
Dental Payments by the Claims Processing System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capitation Payments	$ 2.57	$ 3.70	$ 3.74	$ 2.71	$ 2.86	$ 2.64	$ 2.61
Other Payments/Adjustments to Medical Costs	$ (0.02)	$ (0.01)	$ 0.58	$ 0.19	$ 1.43	$ 0.59	$ (0.05)
Recoveries not in Claims Payments	$ (0.23)	$ (0.21)	$ (0.57)	$ (0.11)	$ (0.23)	$ (0.35)	$ (0.55)
Total Payments for the month	$ 167.42	$ 175.44	$ 170.58	$ 184.03	$ 173.49	$ 192.79	$ 176.95
Remaining IBNR for the month	$ 0.04	$ 0.08	$ 0.13	$ 0.16	$ 0.23	$ 0.49	$ 0.86
Payments and Remaining IBNR for the month	**$ 167.46**	**$ 175.53**	**$ 170.71**	**$ 184.19**	**$ 173.72**	**$ 193.28**	**$ 177.81**
Annual Trend	22%	31%	12%	18%	14%	15%	12%

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE

Reporting Month	2005						
Feb-06	Incurred Month						
	May	June	July	August	September	October	November
Enrollment	429,711	429,259	429,771	418,405	405,866	412,697	416,102
Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 39,402,141	$ 38,015,269	$ 35,898,821	$ 35,147,624	$ 30,026,927	$ 30,610,727	$ 28,687,951
HCFA1500 Payments by the Claims Processing System	37,366,049	37,815,566	36,866,796	37,827,145	33,982,023	34,501,930	33,280,343
Dental Payments by the Claims Processing System	0	0	0	0	0	0	0
Capitation Payments	1,130,111	1,124,049	964,767	969,009	939,849	350,619	1,102,080
Pharmacy Payments	0	0	0	0	0	0	0
Subcontractor Payments for Medical Services	0	0	0	0	0	0	0
Reinsurance Payment	0	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	126,716	100,191	237,404	145,565	463,632	1,638,367	266,891
Less:	0	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0	0
Pharmacy Rebates	0	0	0	0	0	0	0
Recoveries not in Claims Payments	172,487	195,454	389,115	176,340	134,609	243,329	298,810
Total Payments for the month	77,852,530	76,859,621	73,578,673	73,913,003	65,277,821	66,858,315	63,038,455
Remaining IBNR for the month	996,599	1,135,080	1,393,515	1,977,007	2,507,908	3,933,936	7,105,238
Payments and Remaining IBNR for the month	**78,849,129**	**77,994,701**	**74,972,188**	**75,890,010**	**67,785,730**	**70,792,251**	**70,143,693**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month							
UB 92 Payments by the Claims Processing System	$ 91.69	$ 88.56	$ 83.53	$ 84.00	$ 73.98	$ 74.17	$ 68.94
HCFA1500 Payments by the Claims Processing System	$ 86.96	$ 88.09	$ 85.78	$ 90.41	$ 83.73	$ 83.60	$ 79.98
Dental Payments by the Claims Processing System	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capitation Payments	$ 2.63	$ 2.62	$ 2.24	$ 2.32	$ 2.32	$ 0.85	$ 2.65
Other Payments/Adjustments to Medical Costs	$ 0.29	$ 0.23	$ 0.55	$ 0.35	$ 1.14	$ 3.97	$ 0.64
Recoveries not in Claims Payments	$ (0.40)	$ (0.46)	$ (0.91)	$ (0.42)	$ (0.33)	$ (0.59)	$ (0.72)
Total Payments for the month	$ 181.17	$ 179.05	$ 171.20	$ 176.65	$ 160.84	$ 162.00	$ 151.50
Remaining IBNR for the month	$ 2.32	$ 2.64	$ 3.24	$ 4.73	$ 6.18	$ 9.53	$ 17.08
Payments and Remaining IBNR for the month	**$ 183.49**	**$ 181.70**	**$ 174.45**	**$ 181.38**	**$ 167.02**	**$ 171.54**	**$ 168.57**
Annual Trend	17%	7%	5%	1%	-5%	2%	-4%

TennCare **Exhibit 32**

Middle Tennessee Data Book

Medical Fund Target Report

TOTAL MIDDLE TENNESSEE

Reporting Month	2006			TOTAL		
Feb-06	Incurred Month			FISCAL YEAR	FISCAL YEAR	FISCAL YEAR
	December	January	February	2004	2005	2006-YTD
Enrollment	400,732	397,366	386,464	5,036,323	5,148,734	3,267,403
Payments for Medical Services for the Month						
UB 92 Payments by the Claims Processing System	$ 24,060,228	$ 23,376,936	$ 4,159,423	$ 366,172,456	$ 472,415,296	$ 211,968,639
HCFA1500 Payments by the Claims Processing System	30,222,951	26,485,688	5,877,277	339,649,786	423,665,469	239,044,153
Dental Payments by the Claims Processing System	0	0	0	0	0	0
Capitation Payments	435,431	401,530	397,532	47,312,379	14,989,819	5,560,816
Pharmacy Payments	0	0	0	6,029	0	0
Subcontractor Payments for Medical Services	0	0	0	0	0	0
Reinsurance Payment	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	75,728	213,433	124,229	50,820	1,260,455	3,165,249
Less:	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0
Pharmacy Rebates	0	0	0	0	0	0
Recoveries not in Claims Payments	336,556	402,623	263,439	1,067,811	1,633,969	2,244,821
Total Payments for the month	54,457,782	50,074,964	10,295,022	752,123,659	910,697,069	457,494,035
Remaining IBNR for the month	11,255,314	21,823,349	59,198,659	0	2,996,781	109,194,926
Payments and Remaining IBNR for the month	**65,713,096**	**71,898,313**	**69,493,681**	**752,123,659**	**913,693,850**	**566,688,961**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month						
UB 92 Payments by the Claims Processing System	$ 60.04	$ 58.83	$ 10.76	$ 72.71	$ 91.75	$ 64.87
HCFA1500 Payments by the Claims Processing System	$ 75.42	$ 66.65	$ 15.21	$ 67.44	$ 82.29	$ 73.16
Dental Payments by the Claims Processing System	$ -	$ -	$ -	$ -	$ -	$ -
Capitation Payments	$ 1.09	$ 1.01	$ 1.03	$ 9.39	$ 2.91	$ 1.70
Other Payments/Adjustments to Medical Costs	$ 0.19	$ 0.54	$ 0.32	$ 0.01	$ 0.24	$ 0.97
Recoveries not in Claims Payments	$ (0.84)	$ (1.01)	$ (0.68)	$ (0.21)	$ (0.32)	$ (0.69)
Total Payments for the month	$ 135.90	$ 126.02	$ 26.64	$ 149.34	$ 176.88	$ 140.02
Remaining IBNR for the month	$ 28.09	$ 54.92	$ 153.18	$ -	$ 0.58	$ 33.42
Payments and Remaining IBNR for the month	**$ 163.98**	**$ 180.94**	**$ 179.82**	**$ 149.34**	**$ 177.46**	**$ 173.44**
Annual Trend	-4%	-2%	4%		19%	-2%

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE

Reporting Month	TOTAL					
Feb-06	CALENDAR 2003	CALENDAR 2004	CALENDAR 2005	Jan-Mar 2003	Apr-Jun 2003	Jul-Sep 2003
Enrollment	3,734,096	5,148,121	5,051,530	573,649	691,468	1,176,988
Payments for Medical Services for the Month						
UB 92 Payments by the Claims Processing System	$ 240,090,128	$ 441,228,726	$ 420,826,410	$ 36,209,218	$ 42,916,015	$ 73,512,866
HCFA1500 Payments by the Claims Processing System	234,358,922	383,250,853	428,582,924	34,431,695	41,764,561	74,283,977
Dental Payments by the Claims Processing System	1,690	0	0	1,690	0	0
Capitation Payments	35,079,709	33,331,845	11,639,874	6,890,869	6,096,606	10,670,706
Pharmacy Payments	5,294,279	0	0	2,588,842	2,699,409	3,128
Subcontractor Payments for Medical Services	42,444,313	0	0	17,938,241	24,506,072	0
Reinsurance Payment	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	416,142	(94,248)	3,975,174	87,972	70,234	295,577
Less:	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0
Pharmacy Rebates	2,688,613	0	0	1,329,363	1,359,250	0
Recoveries not in Claims Payments	978,416	1,363,635	2,477,443	255,767	283,188	258,712
Total Payments for the month	554,018,154	856,353,541	862,546,938	96,563,397	116,410,460	158,507,542
Remaining IBNR for the month	0	117,486	31,052,213	0	0	0
Payments and Remaining IBNR for the month	**554,018,154**	**856,471,027**	**893,599,151**	**96,563,397**	**116,410,460**	**158,507,542**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month						
UB 92 Payments by the Claims Processing System	$ 64.30	$ 85.71	$ 83.31	$ 63.12	$ 62.07	$ 62.46
HCFA1500 Payments by the Claims Processing System	$ 62.76	$ 74.44	$ 84.84	$ 60.02	$ 60.40	$ 63.11
Dental Payments by the Claims Processing System	$ 0.00	$ -	$ -	$ 0.00	$ -	$ -
Capitation Payments	$ 9.39	$ 6.47	$ 2.30	$ 12.01	$ 8.82	$ 9.07
Other Payments/Adjustments to Medical Costs	$ 0.11	$ (0.02)	$ 0.79	$ 0.15	$ 0.10	$ 0.25
Recoveries not in Claims Payments	$ (0.26)	$ (0.26)	$ (0.49)	$ (0.45)	$ (0.41)	$ (0.22)
Total Payments for the month	$ 136.30	$ 166.34	$ 170.75	$ 134.87	$ 130.97	$ 134.67
Remaining IBNR for the month	$ -	$ 0.02	$ 6.15	$ -	$ -	$ -
Payments and Remaining IBNR for the month	**$ 136.30**	**$ 166.37**	**$ 176.90**	**$ 134.87**	**$ 130.97**	**$ 134.67**
Annual Trend		22%	6%			

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE

Reporting Month	TOTAL					
Feb-06	Oct-Dec 2003	Jan-Mar 2004	Apr-Jun 2004	Jul-Sep 2004	Oct-Dec 2004	Jan-Mar 2005
Enrollment	1,291,991	1,278,253	1,289,091	1,287,114	1,293,663	1,281,027
Payments for Medical Services for the Month						
UB 92 Payments by the Claims Processing System	$ 87,452,029	$ 101,190,681	$ 104,016,880	$ 119,774,549	$ 116,246,616	$ 120,385,982
HCFA1500 Payments by the Claims Processing System	83,878,689	90,028,281	91,458,839	100,740,301	101,023,432	110,445,610
Dental Payments by the Claims Processing System	0	0	0	0	0	0
Capitation Payments	11,421,528	12,177,201	13,042,945	3,795,739	4,315,960	3,505,434
Pharmacy Payments	2,901	0	0	0	0	0
Subcontractor Payments for Medical Services	0	0	0	0	0	0
Reinsurance Payment	0	0	0	0	0	0
Other Payments/Adjustments to Medical Costs	(37,641)	119,401	(326,517)	(120,508)	233,376	941,818
Less:	0	0	0	0	0	0
BHO Capitation Revenue	0	0	0	0	0	0
Pharmacy Rebates	0	0	0	0	0	0
Recoveries not in Claims Payments	180,749	329,620	298,730	305,300	429,985	293,823
Total Payments for the month	182,536,756	203,185,944	207,893,418	223,884,781	221,389,399	234,985,021
Remaining IBNR for the month	0	0	0	8,543	108,943	377,544
Payments and Remaining IBNR for the month	**182,536,756**	**203,185,944**	**207,893,418**	**223,893,324**	**221,498,342**	**235,362,564**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month						
UB 92 Payments by the Claims Processing System	$ 67.69	$ 79.16	$ 80.69	$ 93.06	$ 89.86	$ 93.98
HCFA1500 Payments by the Claims Processing System	$ 64.92	$ 70.43	$ 70.95	$ 78.27	$ 78.09	$ 86.22
Dental Payments by the Claims Processing System	$ -	$ -	$ -	$ -	$ -	$ -
Capitation Payments	$ 8.84	$ 9.53	$ 10.12	$ 2.95	$ 3.34	$ 2.74
Other Payments/Adjustments to Medical Costs	$ (0.03)	$ 0.09	$ (0.25)	$ (0.09)	$ 0.18	$ 0.74
Recoveries not in Claims Payments	$ (0.14)	$ (0.26)	$ (0.23)	$ (0.24)	$ (0.33)	$ (0.23)
Total Payments for the month	$ 141.28	$ 158.96	$ 161.27	$ 173.94	$ 171.13	$ 183.43
Remaining IBNR for the month	$ -	$ -	$ -	$ 0.01	$ 0.08	$ 0.29
Payments and Remaining IBNR for the month	**$ 141.28**	**$ 158.96**	**$ 161.27**	**$ 173.95**	**$ 171.22**	**$ 183.73**
Annual Trend		18%	23%	29%	21%	16%

TennCare

Middle Tennessee Data Book

Medical Fund Target Report

Exhibit 32

TOTAL MIDDLE TENNESSEE

Reporting Month				
Feb-06	Apr-Jun 2005	Jul-Sep 2005	Oct-Dec 2005	Jan-Feb 2006
Enrollment	1,286,930	1,254,042	1,229,531	783,830
Payments for Medical Services for the Month				
UB 92 Payments by the Claims Processing System	$ 116,008,149	$ 101,073,373	$ 83,358,906	$ 27,536,360
HCFA1500 Payments by the Claims Processing System	111,456,125	108,675,964	98,005,224	32,362,965
Dental Payments by the Claims Processing System	0	0	0	0
Capitation Payments	3,372,686	2,873,624	1,888,130	799,062
Pharmacy Payments	0	0	0	0
Subcontractor Payments for Medical Services	0	0	0	0
Reinsurance Payment	0	0	0	0
Other Payments/Adjustments to Medical Costs	205,769	846,601	1,980,986	337,662
Less:	0	0	0	0
BHO Capitation Revenue	0	0	0	0
Pharmacy Rebates	0	0	0	0
Recoveries not in Claims Payments	604,861	700,064	878,695	666,062
Total Payments for the month	230,437,868	212,769,498	184,354,551	60,369,986
Remaining IBNR for the month	2,501,752	5,878,429	22,294,489	81,022,008
Payments and Remaining IBNR for the month	**232,939,620**	**218,647,927**	**206,649,040**	**141,391,994**

Per Member Per Month W/O Pharmacy

Payments for Medical Services for the Month				
UB 92 Payments by the Claims Processing System	$ 90.14	$ 80.60	$ 67.80	$ 35.13
HCFA1500 Payments by the Claims Processing System	$ 86.61	$ 86.66	$ 79.71	$ 41.29
Dental Payments by the Claims Processing System	$ -	$ -	$ -	$ -
Capitation Payments	$ 2.62	$ 2.29	$ 1.54	$ 1.02
Other Payments/Adjustments to Medical Costs	$ 0.16	$ 0.68	$ 1.61	$ 0.43
Recoveries not in Claims Payments	$ (0.47)	$ (0.56)	$ (0.71)	$ (0.85)
Total Payments for the month	$ 179.06	$ 169.67	$ 149.94	$ 77.02
Remaining IBNR for the month	$ 1.94	$ 4.69	$ 18.13	$ 103.37
Payments and Remaining IBNR for the month	**$ 181.00**	**$ 174.35**	**$ 168.07**	**$ 180.39**
Annual Trend	12%	0%	-2%	-2%

ATTACHMENT A

RFP 318.65-219
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
MANAGED CARE ORGANIZATION FOR MIDDLE TENNESSEE
PRE PROPOSAL MEETING
WEDNESDAY, APRIL 19, 2006

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RFP 318.65-219
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
MANAGED CARE ORGANIZATION FOR MIDDLE TENNESSEE
PRE PROPOSAL MEETING
WEDNESDAY, APRIL 19, 2006

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RFP 318.65-219
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
MANAGED CARE ORGANIZATION FOR MIDDLE TENNESSEE
PRE PROPOSAL MEETING
WEDNESDAY, APRIL 19, 2006

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RFP 318.65-219
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
MANAGED CARE ORGANIZATION FOR MIDDLE TENNESSEE
PRE PROPOSAL MEETING
WEDNESDAY, APRIL 19, 2006

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ATTACHMENT B

PROPOSED MEDICAL NECESSITY RULES
3/23/06 DRAFT

1200-13-16-.01 DEFINITIONS

(1) ADEQUATE when applied to a medical item or service shall mean that the item or service, considered as part of a course of diagnosis or treatment, is sufficient, but not in excess of what is needed, for diagnosis or treatment of the particular medical condition. In order for a medical item or service to be determined adequate, such item or service must also satisfy the requirements at 1200-13-16-.05(5) regarding "safe and effective" and the requirements at 1200-13-16-.05(6) regarding "not experimental or investigational."

(2) BEHAVIORAL HEALTH ORGANIZATION shall mean an entity that provides defined behavioral health services under TennCare or traditional Medicaid.

(3) BENEFITS shall mean the defined package of health care services, including long term care services, for which an enrollee is eligible under the TennCare Program including applicable limits on such services.

(4) BUREAU OF TENNCARE shall mean the single State Medicaid agency which is responsible for the administration of the TennCare program.

(5) CASE-CONTROL STUDY shall mean a study in which the study and control groups are selected on the basis of whether they have the disease (cases) rather than whether they have been exposed to a risk factor or clinical intervention. The design is therefore observational (as opposed to experimental) and retrospective (as opposed to prospective), with the clinical outcome already known at the outset. Principal disadvantages of this study design are that important confounding variables may be difficult to identify and adjust for, clinical outcome is already known and may influence the measurement and interpretation of data (observer bias), and participants may have difficulty in accurately recalling past medical history and previous exposures (recall bias).

(6) CASE REPORT shall mean to an uncontrolled observational study (prospective or retrospective) involving an intervention and an outcome in a single patient.

(7) CASE SERIES shall mean an uncontrolled study (prospective or retrospective) of a succession of consecutive patients who receive a particular intervention and are followed to observe their outcomes.

(8) CLINICAL TRIAL shall mean a study that involves the administration of a test regimen to humans to evaluate its efficacy and safety.

(9) CONTROL GROUP shall mean a group of patients that serves as the basis of comparison when assessing the effects of the intervention of interest that is given to the patients in the treatment group. Depending upon the circumstances of the trial, a control group may receive no treatment, a "usual" or "standard" treatment, or a placebo. To make the comparison valid, the composition of the control group should resemble that of the treatment group as closely as possible.

(10) CONTROLLED CLINICAL TRIAL shall mean a clinical trial in which a control group (which receives a standard intervention, which may be no treatment) is compared to a study group (which receives the intervention under study) in order to test a research hypothesis. A controlled clinical trial may or may not be randomized.

(11) CONTROLLED COHORT STUDY shall mean an observational study in which outcomes in a group of patients that received an intervention are compared with outcomes in a similar group i.e., the cohort, either contemporary or historical, of patients that did not receive the intervention. Cohort studies are more subject to systematic bias than randomized trials because treatments, risk factors, and other covariables may be chosen by patients or physicians on the basis of important (and often unrecognized) factors that are related to outcome. Therefore, investigators in controlled cohort studies may identify and correct for confounding variables, which are related factors that may be more directly responsible for clinical outcome than the intervention/exposure in question. For example, in an adjusted- (or matched-) cohort study, investigators identify (or make statistical adjustments to provide) a cohort group that has characteristics (e.g., age, gender, disease severity) that are as similar as possible to the group that experienced the intervention.

(12) CONVENIENCE shall mean the degree to which an item or service is designed or recommended for the personal comfort or ease of an enrollee, caregiver, or provider. Alleviation of pain is not considered a matter of convenience.

(13) COST EFFECTIVE when applied to a medical item or service shall mean that the benefits associated with item or service, considered as part of diagnosis or treatment, outweigh the costs associated with the item or service. When appropriate, such analysis may include assessment of aggregate, population-level data related to the costs or benefits of a medical item or service.

(14) COVERED SERVICES shall mean medical items and services that are within an enrollee’s scope of defined benefits, and not in excess of any applicable limits on such items or services. Covered services include long term care services for those enrollees eligible for long term care. Even in cases of emergency, only a covered service can be determined to be medically necessary for reimbursement purposes under the program.

(15) DIAGNOSIS shall mean the act or process of identifying or determining the nature and cause of a medical problem or condition through evaluation of patient history, examination, and review of laboratory data and other pertinent information. Diagnosis may include cost effective screening services provided in accordance with nationally accepted standards or guidelines developed or endorsed by respected medical organizations, such as the Centers for Disease Control and Prevention.

(16) EFFECTIVE describes the use of a medical item or service that produces the intended result and where the benefit of the medical item or service outweighs the adverse medical risks or consequences.

(17) ELIGIBLE describes a person who has been determined to meet the eligibility criteria for the TennCare program.

(18) ENROLLEE shall mean an individual who is eligible for and enrolled in the TennCare program.

(19) EVIDENCE-BASED shall mean the ordered and explicit use of the best medical evidence available when making health care decisions.

(20) EXPERIMENTAL STUDY shall mean a randomized controlled clinical trial.

(21) HIERARCHY OF EVIDENCE shall mean a ranking of the weight given to medical evidence depending on objective indicators of its validity and reliability including the nature and source of the medical evidence, the empirical characteristics of the studies or trials upon which the medical evidence is based, and the consistency of the outcome with comparable studies. The hierarchy in descending order, with Type I given the greatest weight is:

(a) Type I: Meta-analysis done with multiple, well-designed controlled clinical trials;

(b) Type II: One or more well-designed experimental studies;

(c) Type III: Well-designed, quasi-experimental studies;

(d) Type IV: Well-designed, non-experimental studies; and

(e) Type V: Other medical evidence defined as evidence-based

(i) Clinical guidelines, standards or recommendations from respected medical organizations or governmental health agencies;

(ii) Analyses from independent health technology assessment organizations; or

(iii) Policies of other health plans.

(22) HOME HEALTH SERVICES shall mean any of the following services ordered by a treating physician and provided by a licensed home health agency pursuant to a plan of care at an enrollee's place of residence:

(a) Part-time or intermittent nursing services;

(b) Home health aide services provided by a home health agency;

(c) Medical supplies, equipment, and appliances suitable for use in the home; or

(d) Physical therapy, occupational therapy, or speech pathology and audiology services.

(23) INSTITUTIONAL REVIEW BOARD shall mean a specifically constituted review body established or designated by an entity to protect the welfare of human subjects recruited to participate in biomedical or behavioral research.

(24) LONG TERM CARE shall mean institutional services of a nursing facility, an intermediate care facility for the mentally retarded, or services provided through a Home and Community Based Services (HCBS) waiver program.

(25) MCC (MANAGED CARE CONTRACTOR) shall mean a managed care organization, behavioral health organization, pharmacy benefits manager, or dental benefits manager which has signed a TennCare or Medicaid Contractor Risk Agreement with the State of Tennessee, to manage the delivery and ensure the quality of specified covered benefits to TennCare enrollees through a network of qualified providers. A State government agency (e.g. the Department of Children's Services or the Division of Mental Retardation Services) that has signed an Interagency Contract with the Department of Finance and Administration's bureau of TennCare may perform the functions of a managed care contractor and, if it does, the agency shall be deemed to be an MCC for the purposes of these rules.

(26) MCO (MANAGED CARE ORGANIZATION) shall mean an appropriately licensed Health Maintenance Organization (HMO) contracted with the bureau of TennCare to manage the delivery, provide for access, contain the cost, and ensure the quality of specified covered medical and/or behavioral benefits to TennCare enrollee-members through a network of qualified providers.

(27) MEDICAID shall mean the federal- and state-financed, state-run program of medical assistance pursuant to Title XIX of the Social Security Act.

(28) MEDICAL CONDITION shall mean a disorder or an abnormal condition of the body and/or mind.

(29) MEDICAL EVIDENCE shall mean Type I-IV analyses and studies and/or Type V evidence defined in 12-13-16-.01(21).

(30) MEDICAL ITEM OR SERVICE shall mean an item or service that is provided, ordered, or prescribed by a licensed health care provider and is primarily intended for a medical and/or behavioral purpose and designed to achieve that medical and/or behavioral purpose.

(31) MEDICAL NECESSITY shall mean the quality of being "medically necessary" as defined by Tennessee Code Annotated, Section 71-5-144, and applies to TennCare enrollees. Implementation of the term "medical necessity" is provided for in these regulations, consistent with the statutory provisions, which control in case of ambiguity.

(32) MEDICAL NECESSITY DETERMINATION a decision made by the Chief Medical Officer of the bureau of TennCare or his or her clinical designee or by the Medical Director of one of its Managed Care Contractors or his or her clinical designee regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Tennessee Code Annotated, Section 71-5-144 and these regulations as defined herein. Items or services that are not determined medically necessary shall not be paid for by TennCare.

(33) MEDICAL NECESSITY GUIDELINES shall mean evidence-based guidelines approved by the Chief Medical Officer of the bureau of TennCare for the purpose of guiding medical necessity determinations for particular courses of diagnosis or treatment.

(34) MEDICALLY NECESSARY is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in these regulations, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in these regulations.

(35) MEDICAL RECORD shall mean all medical histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; x-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical documentation in written or electronic format; and analyses of such information.

(36) META-ANALYSIS shall mean systematic methods that use statistical techniques for combining results from different studies to obtain a quantitative estimate of the overall effect of a particular intervention or variable on a defined outcome. This combination may produce a stronger conclusion that can be provided by any individual study.

(37) NON-CONTROLLED COHORT STUDY shall mean a longitudinal study in which a group of people who share a common characteristic or experience are tracked over time with observation of outcomes within the group.

(38) NON-COVERED SERVICE shall mean items and services that are not within the scope of defined benefits for which a beneficiary is eligible under TennCare, including medical items and services that are in excess of any applicable limits on such items or services that might otherwise be covered. Non-covered services under TennCare, including medical items and services in excess of benefit limits, are never to be paid for by TennCare, even if they otherwise would qualify as "medically necessary," regardless of the medical circumstances involved.

(39) NON- EXPERIMENTAL STUDY shall mean a study that is not randomized or controlled. Examples of non-experimental studies include non-controlled cohort studies, case series or case reports.

(40) NON-RANDOMIZED CONTROLLED CLINICAL TRIAL shall mean a controlled clinical trial that assigns patients to intervention and control groups using a method that does not involve randomization, e.g., at the convenience of the investigators or some other technique such as alternate assignment. Controlled trials that are not randomized are subject to a variety of biases, including selection bias, in which persons who volunteer or are assigned by investigators to study groups may differ in characteristics other than the intervention itself.

(41) OFF-LABEL USE shall mean the use of a drug or biological product that has been approved for marketing by the United States Food and Drug Administration (FDA) but is proposed to be used for other than the FDA-approved purpose

(42) PHYSICIAN shall mean a person licensed pursuant to Chapter 6 or 9 of Title 63 of the Tennessee Code Annotated.

(43) QUASI-EXPERIMENTAL STUDY shall mean a study in which the investigator lacks full control over randomization of subjects (lacks full control over the allocation and/or timing of intervention) but nonetheless conducts the study as if it were an experiment, allocating subjects to groups. Examples of quasi-experimental studies include non-randomized controlled clinical trials, controlled cohort studies, or case-control studies.

(44) RANDOMIZED CONTROLLED CLINICAL TRIAL shall mean a clinical trial in which participants are assigned in a randomized fashion to a study group (which receives the intervention) or a control group (which receives a standard treatment, which may be no intervention or a placebo). Randomization enhances the comparability of the groups and provides a more valid basis for measuring statistical uncertainty. In this manner, differences in outcomes can be attributed to the intervention rather than to differences between the groups. Randomized controlled trials may or may not be blinded. In a blinded trial, the investigators, the subjects, or both (double-blinded study) are not told to which group they have been assigned, so that this knowledge will not influence their assessment of outcome.

(45) SCREEN shall mean to test for or examine for the presence of a medical problem or condition in the absence of signs and symptoms of disease.

(46) STUDY shall mean a careful examination or analysis applying scientific methodology and published in a peer-reviewed scientific journal or periodical.

(47) TENNCARE shall mean the TennCare waiver demonstration program(s) and/or Tennessee's traditional Medicaid program.

(48) TREATING PHYSICIAN OR OTHER TREATING HEALTH CARE PROVIDER shall mean a licensed physician practicing within the scope of his or her license or other licensed health care provider practicing within the scope of his or her license who has personally examined a particular TennCare enrollee and who has provided diagnostic or treatment services for that particular enrollee (whether or not those services were covered by TennCare) for purposes of treating or supporting the treatment of a known or suspected medical condition of that particular enrollee. The term excludes all other providers, including those who have evaluated a particular enrollee's medical condition primarily or exclusively for the purposes of supporting or participating in a decision regarding TennCare coverage.

(49) TREATMENT shall mean the provision of medical items or services based on the recommendation of a treating physician or other treating health care provider practicing within the scope of his or her license.

1200-13-16-.02 INTRODUCTION

The medical necessity standard set forth in the TennCare reform statute and in these regulations shall govern the delivery of all medical items and services to all enrollees or classes of beneficiaries in the TennCare program. The definition of medical necessity will be implemented consistent with federal law, including Early Periodic Screening Diagnosis and Treatment (**EPSDT)** requirements, and within the state's authority to define what constitutes a medically necessary Medicaid service. The state recognizes that current EPSDT requirements include coverage of "necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illness and conditions discovered by screening services, whether or not such services are covered under the state plan".

1200-13-16-.03 THE SCOPE OF TENNCARE'S PAYMENT OBLIGATION

(1) Tennessee has an obligation to provide payment on behalf of TennCare enrollees for and only for (a) covered services (b) that are medically necessary.

(2) No TennCare enrollee is entitled to receive non-covered services or covered services that are not medically necessary.

(3) In the context of prior authorization or concurrent review:

(a) When a covered service has been designated by the bureau of TennCare or a managed care contractor as requiring prior approval, no TennCare enrollee is entitled to receive covered services until the favorable conclusion of the prior approval process.

(b) When a covered service has been designated by the bureau of TennCare or a managed care contractor as requiring concurrent review, the enrollee may receive covered services until the expiration of any existing authorization for treatment or until a determination that such service is no longer medically necessary. No TennCare enrollee is entitled to receive covered services subject to concurrent review beyond the expiration of any existing authorization for treatment unless such authorization has been extended through the concurrent review process.

1200-13-16-.04 PRIOR AUTHORIZATION AND CONCURRENT UTILIZATION REVIEW

(1) The bureau of TennCare may identify certain items or services that, for purposes of determining medical necessity, shall require prior authorization and/or concurrent review.

(a) Managed care contractors and/or a state agency performing the function of a managed care contractor shall implement prior authorization and/or concurrent review procedures for all items or services specified by the bureau of TennCare and, at their individual discretion, may require prior authorization and/or concurrent review for additional non-emergency medical items or services not specified by the bureau of TennCare.

(b) Managed care contractors and/or a state agency performing the function of a managed care contractor will inform their enrollees and their participating providers which medical items or services require prior authorization and/or concurrent review. Such notice need not be individualized in nature. Thus, failure to provide individualized prior authorization notices does not invalidate the requirement for prior authorization and/or concurrent review. Notice to providers shall be in writing and such notice requirement may be satisfied by publishing notice on the internet.

1200-13-16-.05 MEDICAL NECESSITY CRITERIA

(1) To be medically necessary, a medical item or service must satisfy each of the following criteria:

(a) It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee;

(b) It must be required in order to diagnose or treat an enrollee's medical condition;

(c) It must be safe and effective;

(d) It must not be experimental or investigational; and

(e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

(2) The convenience of an enrollee, the enrollee's family, the enrollee's caregiver, or a provider, shall not be a factor or justification in determining that a medical item or service is medically necessary.

(3) Services required to diagnose an enrollee's medical condition.

(a) Provided that all the other medical necessity criteria are satisfied, services required to diagnose an enrollee's medical condition may include screening services, as appropriate.

(b) Screening services are "appropriate" if they meet one of the following three categories:

(i) Services required to achieve compliance with federal statutory or regulatory mandates under the **EPSDT** program.

(ii) Newborn testing for metabolic/genetic defects as set forth in Tennessee Code Annotated, Section 68-5-401; or

(iii) Pap smears, mammograms, prostate cancer screenings, colorectal cancer screenings, and screening for tuberculosis and sexually transmitted diseases, including HIV, in accordance with nationally accepted clinical guidelines adopted by the bureau of TennCare.

(c) Unless specifically provided for herein, other screening services are "appropriate" only if they satisfy each of the following criteria:

(i) The bureau of TennCare, a managed care contractor, or a state agency performing the functions of a managed care contractor determines that the screening services are cost effective;

(ii) The screening must have a significant probability of detecting the disease;

(iii) The disease for which the screening is conducted must have a significant detrimental effect on the health status of the affected person;

(iv) Tests must be available at a reasonable cost;

(v) Evidence-based methods of treatment must be available for treating the disease at the disease stage which the screening is designed to detect; and

(vi) Treatment in the asymptomatic phase must yield a therapeutic result.

(d) Services required to diagnose an enrollee's medical condition include diagnostic services mandated by **EPSDT** requirements.

(4) Services required to treat an enrollee's medical condition.
Provided that all other elements of medical necessity are satisfied, treatment of an enrollee's medical condition may include:

(a) Care that is essential in order to treat the symptoms of a diagnosed medical condition and which, if not provided, would have a significant and demonstrable adverse impact on quality or length of life;

(b) Care that is essential in order to treat the significant side effects of another medically necessary treatment (*e.g.*, nausea medications for side effects of chemotherapy);

(c) Care that is essential, based on an individualized determination of a particular patient's medical condition, to avoid the onset of significant health problems or significant complications that, with reasonable medical probability, will arise from that medical condition in the absence of such care;

(d) Home health services

(i) Home health services must meet the criteria of 1200-13-16-.05(1)(a), (c), (d) and (e) and, if the services meet such criteria, they may not be denied on any of the following grounds:

(A) because such services are medically necessary on a long term basis or are required for the treatment of a chronic condition;

(B) because such services are deemed to be custodial care;

(C) because the enrollee is not homebound;

(D) because private insurance utilization guidelines, including but not limited to those published by Milliman & Robertson or developed in-house by TennCare managed care contractors, do not authorize such health care as referenced above;

(E) because the enrollee does not meet coverage criteria for Medicare or some other health insurance program, other than TennCare;

(F) because the home health care that is needed does not require or involve a skilled nursing service;

(G) because the care that is required involves assistance with activities of daily living;

(H) because the home health service that is needed involves home health aide services;

(I) because of a numerical limit unrelated to medical necessity;

(J) because the enrollee meets the criteria for receiving Medicaid nursing facility services; or

(K) on the grounds that such medically necessary home health care is not a covered service; and

(ii) Home health aide services are necessary to treat an enrollee's medical condition if such services:

(A) Are of a type that the enrollee cannot perform for himself or herself;

(B) Are of a type for which there is no caregiver able to provide the services; and

(C) Consist of hands-on care of the enrollee.

or

(e) The following preventive services:

(i) Prenatal and maternity care delivered in accordance with standards endorsed by the American College of Obstetrics and Gynecology;

(ii) Family planning services;

(iii) Age-appropriate childhood immunizations delivered according to guidelines developed by the Advisory Committee on Immunization Practices;

(iv) Health education services for TennCare-eligible children under age 21 in accordance with 42 U.S.C. Section 1396d;

(v) Other preventive services that are required to achieve compliance with federal statutory or regulatory mandates under the **EPSDT** program; or

(vi) Other preventive services that have been endorsed by the bureau of TennCare or a particular managed care contractor as representing a cost effective approach to meeting the medically necessary health care needs of an individual enrollee or group of enrollees.

(5) Safe and effective.

(a) To qualify as being safe and effective, the type, scope, frequency, intensity, and duration of a medical item or service must be consistent with the symptoms or confirmed diagnosis and treatment of the particular medical condition. The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee's needs.

(b) The reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on:

(i) The enrollee's condition; and

(ii) The weight of medical evidence as ranked in the hierarchy of evidence in section 1200-13-16-.01(21) and as applied in sections 1200-13-16-.06(6) and (7) of these rules.

(6) Not experimental or investigational.

(a) A medical item or service is experimental or investigational if there is inadequate empirically-based objective clinical scientific evidence of its safety and effectiveness for the particular use in question. This standard is not satisfied by a provider's subjective clinical judgment on the safety and effectiveness of a medical item or service or by a reasonable medical or clinical hypothesis based on an extrapolation from use in diagnosing or treating another condition. However, extrapolation from one population group to another (e.g. from adults to children) may be appropriate. For example, extrapolation may be appropriate when the item or service has been proven effective, but not yet tested in the population group in question. This standard may only be satisfied if the weight of medical evidence supports the safety and efficacy of the medical item or service in question as ranked in the hierarchy of evidence in section 1200-13-16-.01(21) and as applied in sections 1200-13-16-.06(6) and (7) of these rules.

(b) Subject to the provisions set forth in § (c) immediately below, use of a drug or biological product that has not been approved for marketing under a new drug application or abbreviated new drug application by the United States Food and Drug Administration (FDA) is deemed experimental.

(c) Use of a drug or biological product that has been approved for marketing by the FDA but is proposed to be used for other than the FDA-approved purpose (*i.e.*, off-label use) is experimental and not medically necessary unless the off-label use is shown to be widespread and all other medical necessity criteria as set forth in 1200-13-16-.05(1)(a-c, and e) are satisfied.

(d) Items or services provided or performed for research purposes are experimental and not medically necessary. Evidence of such research purposes may include written protocols in which evaluation of the safety and efficacy of the service is a stated objective or when the ability to perform the service is contingent upon approval from an Institutional Review Board, or a similar body.

(e) Unless a proposed diagnosis or treatment independently satisfies the criteria for "not experimental or investigational", and satisfies all other medical necessity criteria, the fact that an experimental/investigational treatment is the only available treatment for a particular medical condition or that the patient has tried other more conventional therapies without success does not qualify the service for coverage.

(7) The least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the enrollee.

(a) Where there are less costly alternative courses of diagnosis or treatment that are adequate for the medical condition of the enrollee, more costly alternative courses of diagnosis or treatment are not medically necessary, even if the less costly alternative is a non-covered service under TennCare.

(b) Where there are less costly alternative settings in which a course of diagnosis or treatment can be provided that is adequate for the medical condition of the enrollee, the provision of services in a setting more costly to TennCare is not medically necessary.

(c) If a medical item or service can be safely provided to a person in an outpatient setting for the same or lesser cost than providing the same item or service in an inpatient setting, the provision of such medical item or service in an inpatient setting is not medically necessary and TennCare shall not provide payment for that inpatient service, even if the enrollee has exceeded his or her outpatient benefit limits.

(d) An alternative course of diagnosis or treatment may include observation, lifestyle, or behavioral changes or, where appropriate, no treatment at all when such alternative is adequate for the medical condition of the enrollee.

The following is a non-exhaustive illustrative set of circumstances that could fit within the provisions of Section 1200-13-16-.05(7)(d). These examples may or may not be appropriate, depending on an individualized medical assessment of a patient's unique circumstances:

* Rest, fluids and over-the-counter medication for symptomatic relief might be recommended for a viral respiratory infection, as opposed to a prescription for an antibiotic;
* Rest, ice packs and/or heat for acute, uncomplicated, mechanical low back pain along with over-the-counter pain medicine, as opposed to x-rays and a prescription for analgesics;

* Clear liquids and advance diet as tolerated for uncomplicated, acute gastroenteritis, as opposed to prescription antidiarrheals.

(8) The bureau of TennCare may make limited special exceptions to the medical necessity requirements described at 1200-13-16-.05(1) for particular items or services, such as long term care, or such as may be required for compliance with federal law.

(9) Transportation services that the meet the requirements described at 1200-13-13-.04 and 1200-13-14-.04 shall be deemed to be medically necessary if provided in connection with medically necessary items or services.

1200-13-16-.06 DETERMINATION OF MEDICAL NECESSITY

(1) The bureau of TennCare is ultimately responsible for determining whether specific medical items and/or services under TennCare (a) are covered services and (b) are medically necessary. In the vast majority of cases, medical necessity determinations will be made as part of a prior authorization or concurrent review process. However, less frequently such determinations may be made retrospectively in the course of the investigation of unusual billing or practice patterns. The bureau of TennCare may delegate covered services and/or medical necessity decisions to managed care contractors. All medical necessity decisions must be made by licensed medical staff with appropriate clinical expertise. The bureau may review such decisions as a part of routine monitoring or as a result of an enrollee appeal or provider complaint and may overturn such decisions if not made in accordance with these rules.

(2) Non-covered services, including medical items and services in excess of benefit limits, are never to be paid for by TennCare, even if they otherwise would qualify as "medically necessary," regardless of the medical circumstances involved.

(3) If, after an enrollee is provided the opportunity by the State or managed care contractor to consult with a physician, a medical item or service has not been recommended, ordered or prescribed by a treating physician or other treating health care provider practicing within the scope of his or her license, it is not medically necessary and is not covered under TennCare.

(4) In making a medical necessity determination, TennCare or its designee will consider a recommendation, order, or prescription for a covered medical item or service from a treating physician or other treating health care provider.

(a) A recommendation, order or prescription from a treating physician or other treating health care professional shall be based on a thorough, up-to-date assessment of the enrollee's medical condition, with careful consideration of all required medical necessity criteria as defined by statute and by these regulations.

(b) Upon request from the enrollee's managed care contractor or the bureau of TennCare for purposes of making an individualized medical necessity determination, the treating physician or other treating health care provider shall provide information and/or documentation supporting the need for the recommended medical item or service in order to diagnose or treat the enrollee's medical condition.

(c) In addition, when requested, the treating physician or other treating health care provider will provide a written explanation as to why a proposed less costly alternative is not believed to be adequate to address the enrollee's medical condition.

(d) Information/documentation requested by the managed care contractor or the bureau of TennCare for purposes of making a medical necessity determination will be provided free of charge.

(e) Providers who fail to provide information/documentation requested by the managed care contractor or the bureau of TennCare for purposes of making a medical necessity determination shall not be entitled to payment for provision of the applicable medical item or service. In such instances, providers may not seek payment from patients or third parties for items or services denied payment.

(5) The treating physician's conclusory statements, without more, are not binding on the State.

(6) In evaluating the request/recommendation of the treating physician or other treating health care provider, a managed care contractor and/or the bureau of TennCare shall use the hierarchy of evidence to determine if the requested item or service is safe and effective, as referenced at 13-16-.05(5) and (6)(a), for the enrollee by classifying the item or service as having an A, B, C or D level of supporting evidence. In classifying the item or service as having A, B, C or D level of supporting evidence, extrapolation from one population group to another (e.g. from adults to children) may be appropriate. For example, extrapolation may be appropriate when the item or service has been proven effective, but not yet tested in the population group in question.

(a) "A" level evidence: Shows the requested medical item or service is a proven benefit to the enrollee's condition as demonstrated by strong scientific literature and well-designed clinical trials such as a Type I evidence or multiple Type II evidence or combinations of Type II, III, or IV evidence with consistent results. An "A" rating cannot be based on Type III, Type IV, or Type V evidence alone.

(b) "B" level evidence: Shows the requested medical item or service has some proven benefit to the enrollee's condition as demonstrated by:

(i) Multiple Type II or III evidence or combinations of Type II, III, or IV evidence with generally consistent findings of effectiveness and safety. A "B" rating cannot be based on Type IV or V evidence alone; or

(ii) Singular Type II, III, IV, or V evidence when consistent with a bureau of TennCare endorsed or established evidence-based clinical guidelines.

(c) "C" level evidence: Shows only weak and inconclusive evidence regarding safety and/or efficacy for the enrollee's condition such as:

(i) Type II, III, or IV evidence with inconsistent findings ; or

(ii) Only Type V evidence is available

(d) "D" level evidence: Is not supported by any evidence regarding safety and efficacy for the enrollee's condition.

(7) Application of the Hierarchy of Evidence. After classifying the available evidence, the bureau of TennCare or a managed care contractor will approve items or services in the following manner:

(a) Medical items or services with supporting "A" and "B" rated evidence will be considered safe and effective if the item or service does not place the enrollee at a greater risk of morbidity and mortality than an equally effective alternative treatment.

(b) Medical items or services with "C" rated evidence or a physician's clinical judgment that is not supported by objective evidence, will be considered safe and effective only if the provider shows that the requested service is the optimal intervention for meeting the enrollee's specific condition or treatment needs, and:

(i) Does not place the enrollee at greater risk of morbidity or mortality than an equally effective alternative treatment; and

(ii) Is the next reasonable step for the enrollee in light of the enrollee's past medical treatment.

(c) Medical items or services with "D" rated evidence will not be considered safe and effective and; therefore, will not be determined medically necessary.

(8) The bureau of TennCare or the managed care contractor's classification of available medical evidence as described at 1200-13-16-.01(21) and any resulting approval of items or services as described at 1200-13-16-.06(6) and (7) shall be binding on TennCare enrollees and providers.

(9) The managed care contractor or the bureau of TennCare will rely upon all relevant information in making a medical necessity determination. Such determinations must be individualized and made in the context of medical /behavioral history information included in the enrollee's medical record.

(10) The fact that a particular medical item or service has been covered in one instance does not make such item or service medically necessary in any other case, even if such case is similar in certain respects to the situation in which the item or service was determined to be medically necessary.

(11) Items or services that are not determined medically necessary, as defined by the statute or by these regulations, shall not be paid for by TennCare.

1200-13-16-.07 DEVELOPMENT OF EVIDENCE-BASED MEDICAL NECESSITY GUIDELINES

(1) In recognition of the ever-evolving nature of the study and practice of medicine, the growing body of evidence-based medical practice guidelines, the opportunity to achieve cost-containment objectives consistent with quality care, and the existence of practice variability among health care practitioners, the bureau of TennCare may, on occasion, endorse or establish medical necessity guidelines that shall guide determinations of medical necessity for specific items or services across all managed care contractors and State agencies performing the function of managed care contractors.

(2) Such guidelines shall be established with input from managed care contractors, practicing physicians and other health care providers, shall be based on Type I or II evidence and shall take into consideration all criteria of the statutory definition of medical necessity.

(3) The bureau of TennCare will disseminate approved evidence-based medical necessity guidelines to its contractors and the provider community.

(4) The bureau of TennCare will implement a continuous medical review process to ensure that approved evidence-based medical necessity guidelines are responsive to advances in medical knowledge and technology.

1200-13-16-.08 RIGHT TO APPEAL A MEDICAL NECESSITY DETERMINATION

An enrollee may appeal a determination that a medical item or service that is within the enrollee's scope of covered benefits is not medically necessary. In all such appeals, the burden of proof will rest with the enrollee at all stages.